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INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH  
A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY  
OF THE ADMINISTRATION AND OPERATION OF  
VETERANS' ADMINISTRATION FACILITIES

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HEARINGS  
BEFORE THE  
COMMITTEE ON WORLD WAR VETERANS'  
LEGISLATION  
HOUSE OF REPRESENTATIVES  
SEVENTY-NINTH CONGRESS

FIRST SESSION

PURSUANT TO

**H. Res. 192**

(79th Congress, 1st Session)

A RESOLUTION TO DIRECT THE COMMITTEE ON  
WORLD WAR VETERANS' LEGISLATION TO  
INVESTIGATE THE VETERANS'  
ADMINISTRATION

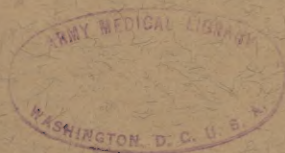
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**PART 5**

JUNE 26, 27, 28, AND 29, 1945

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Printed for the use of the Committee on World War Veterans' Legislation







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SEVENTY-NINTH CONGRESS

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# INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY OF THE ADMINISTRATION AND OPERA- TION OF VETERANS' ADMINISTRATION FACILITIES

TUESDAY JUNE 26, 1945

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WORLD WAR VETERANS' LEGISLATION,  
*Washington, D. C.*

The committee met at 10 a. m., Hon. John E. Rankin (chairman) presiding.

The CHAIRMAN. The committee will come to order.

At this point I would like to read into the record a statement of the number of veterans hospitalized since September 1919 through April 1945.

	Admissions	Remaining	Discharges
World War II.....	165, 514	19, 922	145, 592
All others.....	2, 963, 483	51, 344	2, 912, 139
Total.....	3, 128, 997	71, 266	3, 057, 731

I would like also to call attention to the fact that yesterday President Truman visited the veterans' facility at Portland, Oreg. I would like to read to you the recommendation that he makes regarding that facility. In his speech to the boys he uses this language:

This strikes me as a real hospital, one of the sort we all hope will be the usual thing in the country.

I wanted that information to go into the record because there has been some criticism of that Portland, Oreg., hospital. Of all the hospitals I have visited since I have been a member of this committee, I have turned in more criticism of that hospital than any other that I went through, and that was because of the lack of equipment. Otherwise, I found it to be in splendid condition.

I am glad to know that the President of the United States concurs with me in that opinion now.

Mr. PICKETT. Have the conditions that you criticized been corrected or did the President have the time to make the examination that you and others made?

The CHAIRMAN. I understand the conditions I criticized in 1937, when I was there, have been corrected and they now have the same facilities provided in other veteran hospitals.

We have met this morning to hear certain members of the medical profession. I am going to ask counsel whom he will have first.

General HINES. I would like to present to you and the committee at this time Dr. Griffith, the Medical Director of the Veterans' Administration, who will present these consultants and members of the advisory group in such order as you may desire. He has his ideas as to the order, but the committee can, of course, call on any of them.

Dr. Griffith, will you come forward?

Dr. GRIFFITH. May I introduce Dr. George Morris Piersol, Philadelphia, professor of medicine, Graduate School of Medicine of the University of Pennsylvania; director of the center for institution and research of physical medicine, University of Pennsylvania; medical director of the Bell Telephone Co. of Pennsylvania; editor in chief of the Encyclopedia of Medicine.

#### STATEMENT OF DR. GEORGE MORRIS PIERSOL, PHILADELPHIA, PA.

Dr. PIERSOL. For nearly 20 years I have been able to observe at close range the operation of the Medical Department of the Veterans' Administration.

The CHAIRMAN. You are a practicing physician?

Dr. PIERSOL. I am, sir.

The CHAIRMAN. General practice?

Dr. PIERSOL. Internal medicine.

The opportunity to do so has been afforded through membership on the Medical Council ever since that body was organized in 1924.

In additional, during more recent years, by membership upon a number of special committees appointed by the Administrator of the Veterans' Affairs to advise him on medical matters. As a result of these various activities it has been possible to come in contact with many of the medical personnel of the Veterans' Administration both in the central office in Washington and in the field.

Personal inspection during the last few years of a number of veterans' hospitals has given ample opportunity to observe at first hand the work that is carried on in these institutions. These years of contact with the Veterans' Administration's Medical Department have afforded a basis for certain opinions and impressions concerning this all-important division of the Veterans' Administration.

The impression has been gained that from the Medical Director and the heads of the divisions down, with few exceptions, the medical officers of the Veterans' Administration are an earnest, diligent, conscientious, well-trained group of physicians who have been trying to practice satisfactory medicine in the Veterans' Administration in spite of the many handicaps and restrictions under which they have had to work. It is a tribute to their enthusiasm for medicine and interest in the Administration that under existing circumstances they have accomplished so much and taken such good care of the sick and injured veterans entrusted to them.

Until 1940 the problems were not so acute. Since then, with the outbreak of hostilities, personnel have been steadily depleted until now it is almost impossible to obtain suitable replacements.

Every group with which I have been connected that has ever investigated the medical activities of the Veterans' Administration is in



agreement that the medical services given to our veterans could be improved and that the medical and hospital functions of the Administration are in need of reorganization. The way in which the reorganization and improvement can be effected has been set forth in detail in a special report entitled "Proposed Basic Changes in the Medical Service of the Veterans' Administration," submitted to the Administrator of Veterans' Affairs by the special medical advisory group on May 17, 1945.

This report deals with certain defects that are inherent in the organization of the Veterans' Administration due, in large measure, to the laws and regulations under which the Medical Department of the Veterans' Administration operates. Until certain faults in the present set-up are eliminated it is doubtful whether any group of physicians can render to our veterans the first-class medical care to which they are entitled.

The changes recommended should start with the central office organization. At present the Medical Director of the Veterans' Administration, who is its chief medical officer, is not even an Assistant Administrator. The Assistant Administrator who, along with other responsibilities, represents medicine is a layman through whom the Medical Director reports to the Administrator.

At present, therefore, the Medical Director is not a member of the policy-making group of the Veterans' Administration which is composed of the Administrator and Assistant Administrators.

The Medical Service of the Veterans' Administration is thereby relegated to a subsidiary position not only in theory, according to the organizational set-up, but also in actual practice. The Medical Department can never function properly until its chief medical officer is elevated to the status of an Assistant Administrator, who reports directly to the Administrator and is given full authority and direct responsibility for the conduct of the medical and hospital services.

It is believed that there should be established within the Veterans' Administration an organization comparable to the Bureau of Medicine and Surgery of the Navy, composed of the Assistant Administrator in charge of medical services and the heads of the various professional services, such as medicine, surgery, tuberculosis, neuropsychiatry, radiology, pathology, physical medicine, dentistry, research in post-graduate instruction, rehabilitation, and so forth.

Such a bureau, made up of the heads of the various divisions of the Medical Department, should have full authority to direct the medical policies of the Administration. Their ability to act in all professional matters should not be inhibited by the necessity of having to report to the Administrator through a lay intermediary. The heads of the various divisions should be men of outstanding ability in their respective fields and should be given compensation sufficient to attract physicians of the highest repute to such posts.

Some form of special medical advisory group to the Administrator should be made a permanent part of the organization. Such a group should be charged with the responsibility of critical study of methods and results. Attached to this group should be a full-time medical executive to act as a liaison officer between the advisory group, the Medical Director, the divisional heads, and the Administrator.

A plan should be established for regional consultants in medicine, surgery, tuberculosis, neuropsychiatry, and so forth. These consultants should be outstanding specialists in their respective fields.

The plan to be followed should be patterned along that at present in effect in the Army, where in each service command there are consultants in the major fields of medicine and surgery. These consultants should visit each hospital in the region to which they are assigned at frequent intervals and should remain long enough to go over all the cases that come within their particular field. Such a group of consultants would be in a position to promptly recognize any professional or administrative faults or abuses that might develop from time to time. These should be reported promptly and directly to the chief medical officer and the Bureau of Divisional Heads so that they could be recognized and corrected by the Department at least as soon as they might become evident to the public.

The efficiency of central office medical inspection could be increased by more frequent visits to the various hospitals by the heads of the various medical and hospital services. These inspections should be directed particularly to the medical and professional care of the patients. Such central-office inspections should be regular, thorough, and complete, keeping primarily in mind the quality of the care rendered the patients and paying less attention to administrative details.

Regional offices should be separated from and conducted independently of hospitals. It has been observed that the hospitals operate more effectively when they are divorced from a regional office. When the two are combined the chief medical officer of the hospital is responsible to the manager of the facility, who is almost always a layman and who may or may not be sympathetic with or interested in the medical problems of the institution.

The chief medical officer of a veterans' hospital should be directly responsible to an Assistant Administrator in charge of medical services (now designated as Medical Director).

In each medical facility there should be trained administrative assistants to the chief medical officer appointed to take charge of the administrative details in the management of the hospital. Such administrative assistants could be competent laymen or medical men who prefer administrative work to clinical. Such a group of administrative assistants could relieve the medical personnel of a vast amount of clerical work which at present occupies so much of the time of physicians that their clinical activities suffer therefrom.

There should be appointed to each Veterans' Administration hospital competent consultants recognized as specialists in their respective fields. These consultants should be obtained preferably from local medical schools or medical centers. They should be adequately compensated for their time and professional services rendered, should have regular days for visiting the hospitals and during these occasions they should see all the patients on their respective services, not merely limit their activities to the observation of selected cases.

Serious consideration should be given to the training of interns and residents in medicine, surgery, and the allied specialties in at least the larger Veterans' Administration hospitals.

Plans should be made for the graduate training of the senior staff members. Such graduate training should not be confined to veterans'



facilities. Properly selected physicians should be sent to those medical institutions in this country where the best type of graduate training in any given field is available. The regulations of the medical department should be changed so that it will be possible for the medical officers to attend important national medical meetings without incurring personal financial loss. The medical officers of the Veterans' Administration should be given the opportunity to be certified by the various national specialty boards and they should be urged to become members of certain outstanding medical organizations. In this way the medical personnel could be stimulated to acquire advanced medical education. By this method the Veterans' Administration hospitals can be better assured of well-trained, competent medical officers.

When new veterans' facilities are constructed they should not be placed in remote locations but should be established in recognized medical centers so that the medical and scientific facilities of such centers can be readily made available for the better care of the patients.

The present tendency of new facilities to be located wherever the Army stands ready to transfer a hospital or a camp, regardless of its location and accessibility to a medical center, is unsound and is not calculated to improve the medical care of veterans.

One of the outstanding difficulties with which the medical department of the Veterans' Administration has been confronted and one which more than anything else has militated against the efficiency of medical care is the method by which all medical personnel are selected and the difficulty of obtaining a sufficient number of properly qualified persons.

The present system of obtaining medical and other professional personnel through the civil-service organization is definitely unsatisfactory and should be abandoned as soon as possible. Under the present system the Medical Director has virtually no opportunity to select. Until some method is adopted by which medical personnel can be properly chosen in accordance with their educational background and professional attainments, a first-class, well-trained, efficient group of physicians, nurses, and so forth, cannot be organized.

Under the present system of selection through civil service it is impossible to separate a medical officer who personally, temperamentally, or professionally is unsuited to the work without instituting complicated legal procedures.

Advancement in the service should be dependent upon periodic examinations and should not rest so much upon age, length of service, and the number of patients over which the medical officer is in charge as upon professional efficiency. It should be possible for the proper authorities to drop unsatisfactory or incompetent physicians without resorting to cumbersome and tedious methods.

The present salary schedule is too low to attract the right type of experienced physician to the service.

All these problems could be largely overcome if the present bill, H. R. 3310, now pending before Congress, should be enacted into law, thereby establishing a corps similar to that of the United States Public Health Service not only for physicians but also for dentists, nurses, and other professional and semiprofessional personnel.

The adoption of such a plan would bring about a reorganization of the Medical Department of the Veterans' Administration which, it



is believed, would make this service more attractive to the right type of professional men and women. It would provide an incentive for the medical and other professional officers of the Veterans' Administration to do better work, thereby improving the character of the professional services which are so vital to the adequate and proper care of sick and disabled veterans.

The CHAIRMAN. You have made a very splendid statement. I would like to ask you one or two questions.

You said that the head medical officer in the Veterans' Administration was relegated to a subordinate position. Do you mean by that he is subordinate to the Assistant Administrator?

Dr. PIERSOL. To the Assistant Administrator in charge of medical affairs; yes.

The CHAIRMAN. And you think that the Assistant Administrator should be a physician?

Dr. PIERSOL. Yes.

The CHAIRMAN. You said that we should have a medical division such as is provided in H. R. 3310. You have read that bill, have you not?

Dr. PIERSOL. I have.

The CHAIRMAN. And you approve it?

Dr. PIERSOL. Yes.

The CHAIRMAN. In that connection General Bradley asked us to hold up consideration of that bill until he returns from Europe, which will be around the 1st of August. I agree with you thoroughly. The bill should be passed.

You spoke of the compensation. You said that the physicians are not adequately compensated, but under this bill, H. R. 3310, that deficiency could be met.

Dr. PIERSOL. Yes.

The CHAIRMAN. You also said that the regional office should be separated from the hospital.

Dr. PIERSOL. I think so.

The CHAIRMAN. I agree with you on that. In my State that is done. I thought all along it was a mistake to put the regional office in the hospital.

You say that the civil-service system of selecting physicians is bad and should be abolished or abandoned.

Dr. PIERSOL. That is what I think.

The CHAIRMAN. I agree with you on that. I am glad to hear you bring it out and give your reasons for it.

The other members of the committee are going to ask you questions. I am called to the telephone, and I will ask Mr. Allen to preside.

Mr. ALLEN. Dr. Piersol, I have a question or two that I would like to ask. First, I would like to compliment you on that very constructive statement. I think it is one of the best statements that we have heard.

With reference to the manager of the individual facilities, we have some managers that are doctors and some of them who are businessmen. Do you have a thought on that, Doctor, what we ought to have?

Dr. PIERSOL. In the facilities that I have visited where the regional office and the hospital are connected they work much better when the director is a physician and understands the medical problems than in those instances where he is a layman and is not familiar with the medical situation.

Mr. ALLEN. In other words, you think it is better to have a doctor as manager if you can get the right kind of doctor?

Dr. PIERSOL. I think that where a hospital and a regional office are combined, as they are in some places, that combination works better under the direction of a medical man as manager. Where the regional office is divorced from the hospital and is in another place, then I do not think it makes so much difference. Where the manager confines his activities to the operation of a regional office and has nothing to do with the administration of a hospital, that is all right.

Mr. McQUEEN. May I ask a question there? In other words, your over-all recommendation, Dr. Piersol, would be that the regional office and the hospital in all instances should be separated?

Dr. PIERSOL. Yes.

Mr. McQUEEN. And the regional office would have such management as the Administrator would direct, and any hospital or medical center would be under the direct supervision of a doctor?

Dr. PIERSOL. That is right. That is my idea.

Mr. McQUEEN. And you would separate them in all places?

Dr. PIERSOL. That is my idea.

Mr. ALLEN. Now, with reference to the location of hospitals, or the future location of hospitals, you recommended that they be located in large centers, medical centers, as soon as possible. Of course, the other side of the picture is this: That the Veterans' Administration has taken into consideration the placement of the veteran, the population of veterans in the various States, and they have to endeavor to locate the hospitals where the hospitals will be nearer the bulk of the veterans. For that reason it is not always possible and probably it is not always wise to locate the hospitals in large metropolitan centers. A great many of our States, of course, do not have more than perhaps one large city where you would have a large medical center. You are not contending that it would be wise to locate the hospital in a case like that in the one large city?

Dr. PIERSOL. It is pretty difficult to make a general rule applicable everywhere. My only thought is that in locating any of these hospitals an effort should be made to get them away from some remote place and get them where medical consultation and medical facilities are readily available to the men who are sick, particularly in certain types of cases.

Mr. DOMENGEAUX. Doctor, did you read the magazine articles published in the Cosmopolitan magazine and in PM? The one in Cosmopolitan was written by Mr. Maisel.

Dr. PIERSOL. I did.

Mr. DOMENGEAUX. And the other in PM was written by Mr. Deutsch.

Dr. PIERSOL. I have read them.

Mr. DOMENGEAUX. Apart from their findings of fact, the conclusions they arrived at are more or less similar to the suggestions you are making now.

Dr. PIERSOL. I think in a general way.

Mr. DOMENGEAUX. Naturally, the facts on which the conclusions were based are different.

Dr. PIERSOL. That is my impression.

Mr. DOMENGEAUX. Your conclusions are about the same as to the corrections that should be made in the hospitals.

Dr. PIERSOL. Correct.

Mr. DOMENGEAUX. Doctor, in your statement you stated that the average doctor is overloaded with red tape and routine work.

Dr. PIERSOL. Yes.

Mr. DOMENGEAUX. And he receives small pay, and that his selection when he comes into the hospital is not the most desirable, in that it is difficult to find qualified people through such a civil-service examination.

Would that not indicate that the doctor who went into a veterans' facility in 1940 is an individual who had difficulty in meeting competition in private practice?

Dr. PIERSOL. That is certainly true of some.

Mr. DOMENGEAUX. Is it not true that you did not get the best, or the average medical doctor, to go into the Veterans' Service?

Dr. PIERSOL. I think that is true.

Mr. DOMENGEAUX. Therefore, the Veterans' Medical Service prior to 1940 was administered by inferior men professionally, as a whole?

Dr. PIERSOL. There are undoubtedly men in that medical group who are not up to the standard of many of these lay physicians outside. On the other hand, it is my observation that those who have been in charge of the departments, who head up the big divisions and who have been the chief medical officers of hospitals and the chief surgeons, have been exceptionally good men who were thoroughly interested.

If you take the rank and file all the way down the line there have been a good many men, I think, that would have been misfits outside.

Mr. DOMENGEAUX. The question of their interest and their sympathy toward their patients is not involved. I do believe that they have a conscientious desire to be as kind and helpful as possible, but I am asking you whether their medical attainments were up to the average, as a general proposition.

Dr. PIERSOL. I suppose, taking it broadly and very generally, it probably was not.

The CHAIRMAN. Do you think that in view of the whole civil-service set-up?

Dr. PIERSOL. I would not know about that.

Mrs. ROGERS. I am quite troubled about section 30 of the bill before you. It says:

The Administrator of Veterans' Affairs is authorized to appoint, in addition to the Surgeon General, not to exceed five staff assistants, including a general counsel, in the salary range \$9,000-\$12,000 per annum.

I wonder if that does not open the door for very much the same situation to arise that we are in the midst of today. The legal counsel and the staff assistants will have a great deal of power.

Dr. PIERSOL. I am not entirely clear as to what is referred to in that staff section.

Mrs. ROGERS. There may be a joker in that, and I think it is important to look into it before we pass the legislation. I think that it opens the door, Mr. Chairman, for the same situation to exist that exists today. I think that we ought to look into that.

Doctor, I imagine that you are very much alarmed, just as I am, about the order that the War Department has issued rescinding the transfer of doctors to the Veterans' Administration. Do you know anything about that?



Dr. PIERSOL. No; I do not know about that.

Mrs. ROGERS. I knew about it and spoke about it last week, and I understand that it was made generally public yesterday. The order was that the transfer of doctors to the Veterans' Administration was to be rescinded. Two groups may be transferred. One is the group of doctors, Army doctors, who formerly served with the Veterans' Administration. I think that there are about 100 of them. They may serve with the Veterans' Administration upon request; otherwise, they will be discharged. Also, all men of 64, I understand, whether in the Veterans' Administration or in the Army, will be retired.

There is another group that may be transferred from the Army, and that is the graduating man, the man that has graduated from an Army-approved medical school, if they are not eligible for the Army. So you have only two possibilities of men going from the Army to the Veterans' Administration.

With the retirement of a number of Army men in the Veterans' Administration, the Veterans' Administration's cupboard of doctors is going to be very bare.

I am extremely sorry that General Bradley has asked us to wait until his return before doing anything. I can see, on the other hand, why he wants that to happen. If the Medical Corps is not started, I think that we are going to lose many fine doctors who are being discharged from the Army today.

Dr. PIERSOL. I think that is true.

Mrs. ROGERS. Are you troubled about that situation?

Dr. PIERSOL. I think that is true. It is a very difficult and critical situation, this question of medical personnel.

Mrs. ROGERS. And every day makes a difference.

Dr. PIERSOL. It will take some time. If the corps were started tomorrow, it would be a year or more before you could really get the thing in operation and attract good men.

Mrs. ROGERS. You would know that you were going to be able to attract men.

Dr. PIERSOL. I think so.

Mrs. ROGERS. The right men.

What do you think a consultant should be paid? They can earn very much more on the outside. What would be a fair rate of pay for consultants?

Dr. PIERSOL. That is a pretty hard question to answer. It depends a great deal on who the consultant is and how far away he is. I think it would be very difficult to answer that question just offhand.

Mrs. ROGERS. \$20 is much too low.

Dr. PIERSOL. I think that is too low for the type of consultant that I have in mind.

Mrs. ROGERS. Has the Bureau used your counsel as much the last year as formerly?

Dr. PIERSOL. Well, in the last year the Administrator has called together groups to advise with him much more often than formerly.

Mrs. ROGERS. Does he follow your advice?

Dr. PIERSOL. I think he always receives our recommendations, and I have no doubt acts upon them as best he can under the circumstances.

Mrs. ROGERS. But you feel that as a matter of fact your advice has not been carried out?

Dr. PIERSON. Of course, in the last score of years there have been a great many suggestions, including the creation of a medical corps, which have not been followed yet.

Mrs. ROGERS. It has been a long and uphill fight; has it not, Dr. Piersol?

Dr. PIERSON. I think the first recommendation for that was in 1924.

Mrs. ROGERS. We have not had doctors appearing before this committee either, during that time, which I feel has been very unfortunate—

The CHAIRMAN. We never asked for them.

Mrs. ROGERS. I beg your pardon. I asked for them. I asked that the Surgeon General of the Army and the Navy appear.

The CHAIRMAN. I have been on this committee since 1934, and we have summoned everybody before the committee that has been asked for that I know anything about.

Mr. SCRIVNER. Eighteen months ago one of the first requests I made was to have Colonel Rusk come before the committee.

Mrs. ROGERS. They are here now, anyway, and I am very glad of it.

What did you find in the hospitals that should be changed, Dr. Piersol? Did you find abuses in any of the hospitals?

Dr. PIERSON. No; I never did—never.

Mrs. ROGERS. Were any abuses brought to your attention?

Dr. PIERSON. My personal observation of the hospitals was that the patients were happy, that the doctors were sympathetic, and that they were doing the best they could for them. They labored under the disadvantages of a great deal of paper work and a great deal of routine and regulations which I suppose are inevitable in such hospitals. Their personal care of and interest in the patients in every general hospital to which I have gone, including neuropsychiatric hospital at Coatesville, was in every way satisfactory.

Mrs. ROGERS. When they had a lay manager, you found oftentimes that the doctors were taken away from their patients?

Dr. PIERSON. They were interrupted in their professional work.

Mrs. ROGERS. That meant lack of care.

Dr. PIERSON. It made it difficult for the men to carry out their professional work as efficiently as when they were not interrupted.

Mrs. ROGERS. And you found a shortage of nurses?

Dr. PIERSON. In the last 2 or 3 years there has been a shortage of nurses and attendants and doctors.

Mrs. ROGERS. In many instances you are absolutely correct, the doctors and nurses have performed a remarkable and unselfish service.

Do you feel that the corps bill will attract men of great ambition after it is started?

Dr. PIERSON. I think after it is started and after it has been well recognized, it should attract a number of able young men coming out of the Army.

Mrs. ROGERS. They will feel that there is a future ahead of them?

Dr. PIERSON. Whether they have been in the Army or not—

The CHAIRMAN. You do not confine that to the Army?

Dr. PIERSON. No. I meant that many of them are in the Army now and there will be a great many more looking for the positions a few years from now than there are now.

Mrs. ROGERS. That is why it is so important to get them coming out of the Army today. Do you feel that it would be helpful to have a medical training school at the medical center that will be established here in Washington?

Dr. PIERSOL. A research center of some kind?

Mrs. ROGERS. A research center and a training school.

Dr. PIERSOL. Well, such as they have had at Mount Alto.

Mrs. ROGERS. More than that; such as they have at Walter Reed, a training center for doctors. I do not see why the Veterans' Administration should not have a training center also. That would attract a great many men.

Dr. PIERSOL. I think in the large hospitals there should be something done to create educational activity and training.

Mrs. ROGERS. And that is also true as to nurses?

Dr. PIERSOL. Yes.

Mrs. ROGERS. And the attendants?

Dr. PIERSOL. Yes.

Mrs. ROGERS. Do you approve of paying the attendants more?

Dr. PIERSOL. I do.

Mr. PICKETT. I would like to ask you in reference to H. R. 3310, which you endorsed in general terms a moment ago, whether you have studied that bill closely enough to be able to suggest that it be passed without amendment, or do you have some suggested improvement in the bill that could be made?

Dr. PIERSOL. I have never studied it sufficiently to say that it should be passed without amendment. I think one of the objections that has been raised to it by the medical profession at large is that apparently it was believed it would make possible the placing of doctors in the Veterans' Administration whether they wanted to be placed there or not. It would restrict in some measure the ability of doctors to choose whether or not they would go into the Veterans' Administration.

The CHAIRMAN. This applies only in time of war, does it not?

Dr. PIERSOL. I guess that is true.

Mr. DOMENGEAUX. It would not apply in peacetime. It is voluntary employment. That would not apply in peacetime.

The CHAIRMAN. I do not think so.

Dr. PIERSOL. I guess not.

Mrs. ROGERS. It would not apply in peacetime; I know that.

Mr. ALLEN. It would apply to a physician in the Regular Army, of course.

Mrs. ROGERS. Not in peacetime.

General HINES. The bill is designed so that no one goes in until he passes the board appointed by the President. They voluntarily go in in time of peace. It is a peace organization in time of peace. In time of war the whole set-up of the Medical Bureau of Medicine and Surgery becomes a part of the armed forces. It is not made a part of the Army and Navy, and at that time they are commissioned and held, of course, like officers of the Army and the Navy. Likewise, personnel can be selected through the Selective Service to fill vacancies and avoid the troubles we have had, but in times of peace anyone who joins joins of his own volition.



The CHAIRMAN. Do you have any objection to it under those circumstances, Doctor?

Dr. PIERSOL. No. It was not my own personal objection. I think it was something that was misunderstood by the medical profession at large, and I doubt if they understand the situation.

Mr. PICKETT. You asserted in your original statement that the veterans' facilities be located adjacent or near to some already established medical center. I take it you mean some city or town where there is a clinic recognized as of high caliber.

Dr. PIERSOL. Yes.

Mr. PICKETT. Did you mean to suggest that it should be confined to the largest cities such as Philadelphia and New York, or towns of 40,000 or 50,000, or just any reasonably good-sized town that possessed medical men of some caliber and attainments who could be consultants?

Dr. PIERSOL. That is right; not necessarily big cities like San Francisco, New York, and Philadelphia.

Mr. PICKETT. It might apply to towns of 10,000 or 15,000 to 25,000 in given cases?

Dr. PIERSOL. Yes.

Mr. PICKETT. You understand the general policy the Veterans' Administration follows with reference to the location of those hospitals?

Dr. PIERSOL. I think so.

Mr. PICKETT. There would be nothing in your suggestion that would be counter to their established policy in that connection?

Dr. PIERSOL. No.

Mr. PICKETT. Do you make any distinction along that line?

Dr. PIERSOL. No.

Mr. PICKETT. One further question with reference to the articles that have been published recently criticizing the Veterans' Administration hospitals in various sections of the country.

Have you, since those articles were published, had an opportunity to visit any of the facilities that have been criticized in those articles?

Dr. PIERSOL. No; not this winter I have not; I have not since the articles were published.

Mr. PICKETT. I believe that is all.

Mr. SCRIVNER. Doctor, in your statement you criticized the Veterans' Administration for taking over Army and Navy hospitals. Was that criticism directed toward adopting that as a permanent policy or would you criticize taking them over as a matter of emergency during a period of building?

Dr. PIERSOL. My thought was in reference to their geographical location. Many Army hospitals are in fairly remote spots as far as medical facilities are concerned. If you took them over you would be no better off than if you put up a veterans' hospital in a remote spot.

Mr. SCRIVNER. Then it is your suggestion that doctors should be the managers of all these hospitals. Have you not found in your visits that some of the best hospitals that we have have been managed by laymen?

Dr. PIERSOL. There are lay managers and there are medical directors, also.

Mr. SCRIVNER. So it is a matter largely of a man's personal managerial ability that determines whether he is better fitted to manage a hospital; is that not true?

Dr. PERSOL. I think as a general principle—and this applies to civilian hospitals—the best hospitals in the United States are managed by medical directors and not by lay directors.

Mr. SCRIVNER. You made the suggestion that the medical officer was not now an assistant administrator with full authority. Is there anything under the present existing law that makes that impossible?

Dr. PERSOL. Not that I know of.

Mr. SCRIVNER. You do not need to pass a law to get that job done.

Dr. PERSOL. Oh, no; I do not think so.

Mr. SCRIVNER. Then we will come down to the question of the patient load that we now have. I think the figures shown here previously indicated that about 60 percent of the veterans in hospitals were non-service-connected cases. We are faced now with a shortage of doctors and attendants, and incidentally, as far as the Army's order is concerned, I am not much alarmed about it after having seen some of the things that have happened under it and some of the doctors we will see.

Getting back to the 60 percent of non-service-connected cases, is there not an indication that there might be a necessity in order to give the service-connected cases the care and attention they deserve and should have the non-service-connected cases will have to be handled in some other way?

Dr. PERSOL. If the service-connected load gets so great—and that will be the first thing to handle—then the non-service-connected cases would have to be taken care of some other way.

Mr. SCRIVNER. The disabled men will have to come first, and if our hospitals are overcrowded due to non-service-connected cases, by curtailing somewhat our non-service-connected cases we will be able to give more attention to the service-connected cases.

Dr. PERSOL. I think so.

Mr. SCRIVNER. You mentioned the handicaps and restrictions under which these doctors have to work. Would you care to specify in some detail these handicaps and restrictions to which you referred?

Dr. PERSOL. I was referring particularly to the amount of clerical work, the paper work, that they have had to perform every day. Also, to the fact that they frequently have to go through a good deal of administrative red tape before certain things can be done.

Mr. SCRIVNER. Has your committee made any suggestions to the Veterans' Administration about eliminating some of those handicaps and restrictions?

Dr. PERSOL. Yes.

Mr. SCRIVNER. And have any of your suggestions been adopted?

Dr. PERSOL. Yes.

Mr. SCRIVNER. How many have not?

Dr. PERSOL. I would not know mathematically. I think that all our suggestions recently have been acted upon as best they could under the circumstances.

Mr. SCRIVNER. What do you mean by recently?

Dr. PERSOL. In the last year.

Mr. CARNAHAN. You spoke of the membership of the veterans' doctors in professional organizations as though there might have been some restrictions, or is it more difficult for members of the veterans' facilities to belong to these organizations than other doctors?

Dr. PIERSOL. Yes; it is.

Mr. CARNAHAN. What is the set-up?

Dr. PIERSOL. I think largely because they are moved around from place to place so that they have difficulty in establishing membership in county medical societies, because they are not in any one place long enough, and that means if they cannot get into a county medical society then, of course, they are in a position automatically where they cannot become members of the American Medical Association. Then there are some of these other organizations such as the American College of Physicians and Surgeons where the question of residence is not so important, but where the question of professional attainments is, these men have often not had an opportunity to carry on enough professional work of a high order to qualify.

Mr. CARNAHAN. Of course, that would be a matter for the Medical Association to take care of, would it not, the arranging of their rules by which the membership could be had?

Dr. PIERSOL. As far as the American Medical Association is concerned, that is true.

Mr. CARNAHAN. In the location of training camps, as I understand it, you realize that the military training camps are located in isolated places on purpose. That is the type of place that they need.

Dr. PIERSOL. That is right.

Mr. CARNAHAN. Certainly that is not a proper location for a veterans' hospital.

Dr. PIERSOL. No, sir.

Mr. CARNAHAN. Even though those hospitals are already built and at a considerable expense, do you think that we should still perhaps forget the idea of locating veteran hospitals in the training camps and relocating the veteran hospitals to the best advantage for the years to come?

Dr. PIERSOL. I think if the proper object is to give the veterans the best medical care, that is the thing to do.

Mr. CARNAHAN. You have a private practice; is that right?

Dr. PIERSOL. That is right.

Mr. CARNAHAN. And you have had considerable connection with private hospitals?

Dr. PIERSOL. Yes.

Mr. CARNAHAN. As well as veteran hospitals?

Dr. PIERSOL. Yes.

Mr. CARNAHAN. What, in your opinion, is the relationship between the two? How do they rate?

Dr. PIERSOL. The veterans' facilities that I personally inspected, as I have said in reports to the Administrator, compare very favorably with the clinical work, the records they keep, with any private hospital.

Mr. RAMEY. In the ethics of your profession the doctor stands out at the head, of course, and the nurses are taught to respect your profession so they obey you. Now, in the eight hospitals that I visited I found that the great problem was the problem of attendants. Here is what they said: They said that the doctors just spent a moment with the patients, or gave the order to the nurses. In some hospitals, especially like the one in Dayton, Ohio, you have the nurse in her room with the medicines. Someone rings the buzzer and she directs an attendant to go to that patient. The attendants say that after all the



doctors see them for just a minute. The patients are treated by some of the outstanding physicians. In Dayton, Ohio, one of the greatest surgeons in the country is in charge. The veterans feel safe about an operation there. The veteran gets no recognition from the physician, professional recognition. He does not get to see him. That is the reason that the veteran occasionally complains and says that, after all, when we were overseas, we were treated like kings, but when we get into a veterans' hospital we are the forgotten man. He feels that he does not have personal recognition from the physician. He would like to talk things over with the physician. About the only person that sees him is that attendant. They are under the nurse. At present wages we can hardly get attendants. So the nurse will get her bottle of mendutol and give him something to put him to sleep so that he will not ask questions.

Now, I am disturbed about the situation of attendants. If we have a surgeon general and his decisions are controlling, and if we work out something that the attendants will be all veterans, all brothers, dignified with the title of technicians, so he, too, is recognized as a professional, so the attendant is not one of a group that does not get the recognition?

When the doctors work out something like that, so that that attendant will be professional, too, the same as the nurses and the doctors—that is, recognized as that by the veterans—can something like that be worked out?

Dr. PIERSON. He is practically an orderly.

Mr. RAMEY. Yes.

Dr. PIERSON. And it is very difficult in the best civilian hospitals to get good orderlies now. That problem is not peculiar to the veterans' hospitals; it is prevalent in all hospitals.

Mr. RAMEY. Yes; but so many will be in our veterans' hospitals, and I found the real situation of the veterans; he wants to talk to someone, and the only one he can talk to who can give a good deal of time is an attendant.

If that was a veteran of this war and that was made a profession, would that veteran in the hospital not feel then, well, I am not just shoved around; I am recognized?

Dr. PIERSON. He probably would. It would be a good psychological approach to the thing.

All patients feel just like these boys do. And you can go into the wards of any big hospital. It is the same thing. The surgeon sees them. He does a professional job well enough, but, after all, the patient, whether he is a veteran or not, wants a personal human touch.

Mr. RAMEY. Yes.

Dr. PIERSON. To sit down and talk an hour does him a lot of good.

Mr. RAMEY. Yes.

Dr. PIERSON. Now, you have a hundred people in the ward, and you cannot sit on the side of the bed and hold their hands and listen to them all day long. You have to go along, and it is the problem of finding the people for attendants in hospitals who have the proper psychological approach and sympathy in dealing with patients.

What you find in the veterans' hospitals you will find in Massachusetts General, or any other hospital today, patients being the same the world over.

What they want is attention and persons fussing over them.

The CHAIRMAN. What is that, Doctor?

Dr. PERSOL. Well, I say, whether they are in the veterans' hospitals or in a private hospital, they want attention.

The CHAIRMAN. You say the orderlies are no better in private hospitals?

Dr. PERSOL. That is right.

The CHAIRMAN. Is Dayton an NP hospital?

Dr. PERSOL. No; Chillicothe. They have an outstanding surgeon there. But the persons who do complain say they just do not get the treatment.

When the recognition is not there, they kind of feel, well, kind of pushed around.

Mr. CUNNINGHAM. Dr. Piersol, may I interpose a question right there?

Dr. PERSOL. Yes.

Mr. CUNNINGHAM. What would be the situation if we would dispose of these hospitals and then give them money, let them select their own doctors? What would be the result? Or would you care to express an opinion?

Dr. PERSOL. That would involve a pretty big question, would it not?

Mr. CUNNINGHAM. Yes.

Dr. PERSOL. I suppose it would have the same results as with all private patients, some would go to good doctors, some would waste their money with poor doctors.

Mr. CUNNINGHAM. Well, would the veterans, as a whole, be any better off?

Dr. PERSOL. He would probably be worse off. Because now he is in a place where they have good facilities and excellent men at the head of the service, and where he is going to get legitimate scientific medicine practiced on him and does not have the opportunity to do all sorts of fool things that he would have if he would go off for himself.

Mr. CUNNINGHAM. Then the statement that they are not getting the treatment they should get in private hospitals is a little far-fetched?

Dr. PERSOL. That is not true. The same situation pertains to any hospital in the world.

The CHAIRMAN. What is that question?

Mr. CUNNINGHAM. Will the reporter read it?

(The question was read.)

Dr. PERSOL. My answer is that it is far-fetched.

Mr. CUNNINGHAM. Now, your private—you are a private physician?

Dr. PERSOL. Yes, sir.

Mr. CUNNINGHAM. And you gentlemen are a little concerned as to whether there is ever going to be socialized medicine?

Dr. PERSOL. Some of them are.

Mr. CUNNINGHAM. Is it your opinion that the wider the veterans' hospitals get the closer we are getting to socialized medicine?

Dr. PERSOL. Yes.

I mean the more people who are taken care of in Government hospitals, veterans, or otherwise, is a big entering wedge for socialized medicine.

Mr. CUNNINGHAM. If we would have another war like the one we are in, eventually all hospitals would be Government hospitals, would they not, Doctor?

Dr. PIERSON. I guess many would be Government hospitals; I do not think all of them would.

The CHAIRMAN. That would not be the case if these hospitals were confined to service-connected cases, tubercular and neuropsychiatric cases, would it?

Dr. PIERSON. If they were—if they would confine their efforts to service-connected disabilities.

The CHAIRMAN. Well, now the neuropsychiatric and tubercular have to be taken care of in some kind of institutions, do they not?

Dr. PIERSON. Most of them—many of them do.

The CHAIRMAN. Excuse me, Mr. Ramey. I believe we are on your time on this. Were you through?

Mr. RAMEY. I believe so, for the present.

The CHAIRMAN. Mr. Auchincloss?

Mr. AUCHINCLOSS. Doctor, I believe you answered a question of Mr. Ramey or Mr. Scrivner about the excess duties that the manager of a hospital has, so that it circumscribes his ability to operate.

Is the cure to that the decentralization of the general system of management in the Veterans' Administration, giving the manager of a hospital greater latitude, greater power, authority?

Dr. PIERSON. You mean so that he would not have to appeal to central office?

Mr. AUCHINCLOSS. If he wanted to get a typewriting machine, he would not have to apply to the central office for it.

Dr. PIERSON. I think on general principles that is true. I think now they are held down. They are subject to a good deal of delay, on the other hand, there are many things that can be settled better by competent administrators in the central office than men in the field.

But I think they should have more latitude than they have now, personally.

Mr. McQUEEN. Now, I would like to ask a question or two.

The CHAIRMAN. Yes.

Mr. McQUEEN. Doctor, you stated the changes should start with the central office, and in response to questions, and in your statement, your main point is that authority should be in a medical director on a level with the Assistant Administrator. Is that your main—

Dr. PIERSON. That is the first basic principle.

Mr. McQUEEN. And from the medical standpoint that would take care of, you believe, the situation from a medical standpoint, that is, if he were placed on that level.

Now, in response to other questions, you stated that you believed that every hospital should be managed by a physician; and then you stated that there was a great deal of paper work.

Is it your opinion that a hospital could be better operated with a lay manager, with a medical head who reports to him, or would you have a doctor actually in charge of the administration of the hospital?

Dr. PIERSON. I would have a doctor in charge with properly qualified lay people under him reporting to him, and the corps administrative men such as they have in the Army. Administrative corps for example, could take care of the paper work, the matter of supplies, buying food, all that sort of thing.



Mr. McQUEEN. Well, is it not a fact that a great many of the well-operated and managed civilian hospitals have a lay manager and the staff merely looks after—of course, the medical staff takes care of the medical end; but the hospital is under the charge of the lay manager. Is that not true?

Dr. PIERSOL. That is true of some hospitals.

Mr. McQUEEN. Well, do you believe those hospitals are more efficiently operated than the other hospitals, or would you say the reverse?

Dr. PIERSOL. I think the ones where the best professional work is carried out are those under the direct charge of the medical director.

Mr. McQUEEN. And the lay personnel is under him?

Dr. PIERSOL. Yes.

Mr. McQUEEN. As to the management of the hospital and all of that?

Dr. PIERSOL. Yes.

Mr. McQUEEN. Now you spoke of the fact that it is very hard for some of these medical men to belong to the societies that they probably wanted to belong to, and so forth.

There has been some testimony here that the personnel, the medical personnel, the professional personnel in veterans' hospitals, should be rotated, the same as in the Army, on a 2-year tour.

What are your ideas about whether or not the doctor should be located in New York or Fort Lyons, Colo., and stay there, or should he be rotated—where should he be located?

Dr. PIERSOL. I think they should be placed in the position where they are able to do the particular kind of work they do best.

In other words, if you had a fine chest surgeon and he was in New York City and had a set-up there where he did this work for example, he ought to be allowed to stay there.

The same way with the Mayo Clinic surgeons, who do not want to rotate them to San Francisco or Chicago.

And they ought to be allowed to build up an organization that is adapted to carry on the special thing they are qualified for.

Mr. McQUEEN. Then as a matter of policy, you would not recommend a rotation of medical personnel, at least, among the hospitals, at a given period?

Dr. PIERSOL. I would not be in favor of a fixed policy of that kind. I think that is all an individual matter.

Mr. McQUEEN. Now, you spoke of the fact that the records were very well kept, and you also spoke of the fact that there is a great deal of paper work. What would be your suggestion which might help the records which must be kept in veterans' hospitals, probably kept in private hospitals, and yet give the same service to the veteran?

What would be your suggestion on that?

Dr. PIERSOL. Better organized and greater secretarial help, the introduction of time-saving devices such as dictaphones, and so forth.

Mr. McQUEEN. Is it feasible for the highly professional men in taking care of patients to delegate this work of records to someone else?

Dr. PIERSOL. No; the doctor has to be the man to install—to initiate the records, but if he sits down and in longhand has to write it all out, it is a laborious thing. Whereas if he can dictate it to a secretary or administrative assistant or dictaphone, he saves time.

Mr. McQUEEN. And the record would be just as good and would answer the same purposes, you say, as if he wrote it all out?

Dr. PIERSOL. That is the way the records are kept and written out in most of the big civilian hospitals.

Mr. McQUEEN. Now, as to inspection of hospitals which you spoke of in your dissertation there, what would be your suggestions—

The CHAIRMAN. Mr. McQueen, how many more questions have you?

Mr. McQUEEN. Just one more.

The CHAIRMAN. We want to meet that roll call.

Mr. McQUEEN. What would be your suggestion about the inspection of hospitals, whether that should be done by an outside board?

Dr. PIERSOL. I think there should be fewer types of inspection. I think the professional group should make more frequent inspection and pay more attention to the professional side.

In addition to that, I think they should make definite systematic visits at which time they direct their attention to that particular group in which they are interested?

Mr. McQUEEN. In other words, they should be independent of the administration altogether and make their reports to the administration of their inspection?

Dr. PIERSOL. Make their reports to the medical director.

Mr. McQUEEN. What would be your suggestion as to the kind of set-up that should be, in the form of this advisory group? Or something else?

Dr. PIERSOL. If you had an advisory group—I think they should make their report to the Chief of the Medical Service. Then he can bring that up to an advisory group.

Mr. McQUEEN. That is all, Mr. Chairman.

Mrs. ROGERS. I have just one question. You spoke of the veterans' hospitals which are well run. Which are the best?

Dr. PIERSOL. I think the best veterans' hospital I was in was the one at Aspinwall outside of Pittsburg.

I think the one at the Bronx is a well-run hospital.

Mrs. ROGERS. How about Hines?

Dr. PIERSOL. I have never been there.

Mrs. ROGERS. What kind of contribution do you think the Veterans' Administration has made to medicine and surgery?

Dr. PIERSOL. They published a bulletin which, if not widely read, should be, because it contains a great deal of very excellent medical observation.

Mrs. ROGERS. I think that should go in the record, Mr. Chairman. I think it would be helpful.

The CHAIRMAN. His statement may go in the record but it is not necessary to put the pamphlets in there.

Mrs. ROGERS. Oh, no. His statement along that line.

The CHAIRMAN. Mr. Domengeaux?

Mr. DOMENGEAUX. On that particular question, do you know of any particular contribution that the doctors of the Veterans' Administration have made toward the advancement of medicine or science outside of treatment in osteomyelitis and treatments in cancer at the Hines foundation?

Do you know of any other contribution that doctors in the Veterans' Administration in 30 years have made toward the advancement of medicine?

Dr. PIERSON. I think so. I cannot specify the various articles right now but I have read a great many of them.

I think they have done outstanding work in cancer.

Mr. DOMENGEAUX. Yes.

Dr. PIERSON. I think they have done good work in neuropsychiatry. And there have been a good many surgical contributions made. That is all offhand. I would have to look it up.

Mr. DOMENGEAUX. Doctor, do you know in your inspections of these hospitals whether these activities toward making it possible for the doctor in the veterans' facility to keep up with his profession were made available to these doctors by the central office, and does the doctor in the veterans' hospital keep up with his profession, and is he encouraged to do so?

(Mr. Domengeaux assumes the chair.)

Mr. DOMENGEAUX. Doctor, is he encouraged to do so by the central office?

Dr. PIERSON. He is encouraged to do so, and in most of the hospitals, or all that I have ever visited, they have periodical weekly and bimonthly conferences at which they get their professional groups together, which are scientific meetings, in which they assign subjects and go over the clinical material.

I think possibly they may not have been urged as much as possible to go to some of the national meetings, and I think that it is due to the fact that it is hard for them to get the time, and there are certain arrangements about their pay and allowances, and so forth, that puts some financial burden on them.

Mr. DOMENGEAUX. I had this experience, Doctor, when the opportunity to look at some of these hospitals, one at Biloxi, Miss., where the head surgeon, who had been there since the Veterans' Administration was organized, had come right out of medical school and from that time to the present time, the fact that he had requested to attend certain clinical schools that he had never been allowed—I will not say allowed—but he has never attended any clinical school or refresher course notwithstanding the fact that he was head surgeon, since commencing some 21 years ago.

Do you consider that a desirable situation?

Dr. PIERSON. No; I think that is one of the things that should be corrected, and an opportunity should be given these men to go to postgraduate courses, to be paid, let them take the time out to go, even though it takes months or years, if necessary.

Mr. DOMENGEAUX. But there has been no attempt on the part of the Veterans' Administration to do that, has there?

Dr. PIERSON. No. I think not.

Mr. DOMENGEAUX. And that is absolutely essential in an organization of this kind?

Dr. PIERSON. I think so.

Mr. DOMENGEAUX. How else can a doctor keep posted in his profession unless such a movement prevails?

Dr. PIERSON. He cannot.

Mr. DOMENGEAUX. Now, have you not found this also, Doctor, that in many instances doctors were assigned to certain specialty where they had no aptitude or training or inclination for that particular type of work?



Dr. PIERSOL. I imagine that has happened.

Mr. DOMENGEAUX. You do not know that of your own knowledge?

Dr. PIERSOL. I could not specifically cite the instance.

Mr. DOMENGEAUX. You have made no study in that direction to find whether the doctors were properly fitted to carry on their work?

Dr. PIERSOL. I think some of them have been assigned to do things for which they had never had enough professional training in certain lines.

Mr. DOMENGEAUX. Now, is it not a fact that in the tuberculosis hospital, a doctor, irrespective of his previous tuberculosis training, is given a very short course, most of which is paper work, that thereafter he is considered a tuberculosis specialist?

Dr. PIERSOL. I do not know whether he is considered a tuberculosis specialist, but he is often assigned to take care of tubercular patients.

Mr. MCQUEEN. Will you announce now at 1:30—

Mr. DOMENGEAUX. Yes. We are going to stand adjourned to meet again at 1:30.

(Whereupon the committee recessed until 1:30 p. m. of the same day.)

#### AFTERNOON SESSION

The committee met at 1:30 p. m., Hon. John E. Rankin (chairman) presiding.

The CHAIRMAN. The committee will come to order.

Dr. GRIFFITH. Dr. Max Cutler, former director, Michael Reese Hospital, Chicago; a former instructor in pathology, Cornell Medical School and Memorial Hospital, New York; former director, New York City Cancer Institute; associate in surgery, Northwestern University; past president, American Association for the Study of Neoplastic Diseases.

#### STATEMENT OF DR. MAX CUTLER, CONSULTANT IN CANCER, AT HINES HOSPITAL, CHICAGO, ILL.

The CHAIRMAN. Doctor, give your name and address.

Dr. CUTLER. Dr. Max Cutler, Drake Hotel, Chicago.

The CHAIRMAN. Dr. Cutler, you are a practicing physician?

Dr. CUTLER. Yes, sir.

The CHAIRMAN. Where do you practice?

Dr. CUTLER. Chicago.

The CHAIRMAN. How long have you practiced?

Dr. CUTLER. Since 1924.

The CHAIRMAN. What school are you from?

Dr. CUTLER. Johns Hopkins.

The CHAIRMAN. Where did you take your literary course?

Dr. CUTLER. University of Georgia.

The CHAIRMAN. University of Georgia. You graduated from Johns Hopkins in 1924?

Dr. CUTLER. 1922.

The CHAIRMAN. What did you do from 1922 to 1924?

Dr. CUTLER. I was resident house surgeon in Johns Hopkins Hospital. I was there 1 year; then I was at Michael Reese Hospital in Chicago.

The CHAIRMAN. So you have been a practicing physician in Chicago since that time?

Dr. CUTLER. No, sir; between 1930 and 1934 in New York, and then in Chicago.

The CHAIRMAN. Are you a specialist?

Dr. CUTLER. Yes, sir; in cancer.

The CHAIRMAN. You are a cancer specialist?

Dr. CUTLER. Yes, sir.

The CHAIRMAN. That is what I want to get around to. We are glad to have you. The other members of the committee will come in as we proceed.

Dr. CUTLER, before you start in, are you a consultant at the veterans' hospital in Chicago?

Dr. CUTLER. Yes, sir; I am consultant in cancer at the Hines Hospital.

The CHAIRMAN. How long have you occupied that position?

Dr. CUTLER. Since 1931.

The CHAIRMAN. Thank you. You may proceed.

Dr. CUTLER. For the past 14 years it has been my privilege to serve as consultant in cancer and director of cancer research in the Edward Hines, Jr., Hospital of the Veterans' Administration. During this same period I have been director of the tumor clinic of the Michael Reese Hospital—1931-38—and since 1938 director of the Chicago Tumor Institute. Throughout this period I have engaged in private practice in Chicago.

Within several months after my arrival in Chicago in 1931 I was invited to visit the Hines Veterans' facility with a view to accepting the position as consultant in cancer. When I began my work as consultant in 1931 there were approximately 100 beds set aside for cancer patients. Today there are almost 600 cancer beds.

My work has consisted of regular weekly visits to the Hines Hospital and numerous visits to central office in Washington for conferences with the Administrator and Medical Director and their staffs. Also, before the war, annual inspection visits to the subsidiary cancer units, at Washington, D. C., Bronx, N. Y., Atlanta, Ga., Portland, Oreg., and Sawtelle, Calif.

The CHAIRMAN. Doctor, will it disturb you to interrupt you at that point? You say when you began there were 100 patients, I believe you said 90.

Dr. CUTLER. About 100.

The CHAIRMAN. About a hundred cancer patients and now there are 600?

Dr. CUTLER. Yes.

The CHAIRMAN. Will you explain why that increase?

Dr. CUTLER. Because the Hines Hospital is the one hospital in the Veterans' Administration that is especially interested in cancer.

The CHAIRMAN. In other words, it is because their treatment of cancer has attracted these men there. Is that it?

Dr. CUTLER. I think so.

The CHAIRMAN. Would you say that has caused this increase?

Dr. CUTLER. Well, they are also sent there by the Director from the central office.

Mrs. ROGERS. Is it not true that you have a very fine record of cure of cancer of the thorax at Hines?

Dr. CUTLER. What form?

Mrs. ROGERS. Cancer of the thorax.

Dr. CUTLER. Cancer of the throat, yes. Larynx, yes; we have been doing special work.

Mrs. ROGERS. It has been very successful.

Dr. CUTLER. Yes.

Mrs. ROGERS. And is it not true, also, that, due to the very fine work of the cancer society that cancer is recognized earlier than it was formerly?

Dr. CUTLER. Yes.

The CHAIRMAN. Would you say there is a general increase or decrease in the United States?

Dr. CUTLER. We know that cancer is on the increase, but we are not absolutely certain of the reason why.

Mrs. ROGERS. Is it because they discover it earlier?

Dr. CUTLER. One reason is that people are being saved by the new developments from deaths from other causes, so they live to be older and the older one gets the more likely he is to develop cancer.

There are also other cancers, as for example, cancer of the lungs. I think there is no question but that there is an increase in incidence of cancer of the lungs.

I have also directed the treatment of veterans in the Chicago Tumor Institute. In a constant effort to maintain and advance the standards of treatment I have made numerous visits to cancer centers in this country and abroad. In view of the fact that until the outbreak of the present war, the most advanced work in the X-ray and radium treatment of cancer came from the Curie Institute in Paris, I made annual visits to Paris for many years in order to familiarize myself thoroughly with these advances.

I also arranged for members of the staff of the Curie Institute to come to this country for conferences and lectures, and finally Dr. Henri Coutard, chief of the X-ray department of the Curie Institute, joined the staff of the Chicago Tumor Institute for a period of 3 years, during which time he made numerous visits to the Hines Hospital and assisted with the development of new methods.

The results in the treatment of cancer in 1931 were most discouraging. The great majority of the cases were advanced and cures were so few as to be in the realm of medical curiosities. In this respect the conditions were precisely similar to those in the New York City Cancer Institute, which I directed in 1930 and 1931.

The patients whose cancers were not too advanced were treated surgically with limited success and with certain exceptions (cancer of the skin and lip) X-rays were—and radium—were used largely for the relief of pain.

Between 1924 and 1931 I had spent considerable time in the Curie Institute of Paris with Madame Curie and the medical staff where I had an opportunity to learn a special method of X-ray treatment devised by Dr. Courtard and widely known as the Courtard technique.

This new X-ray method was then the only one that offered any real hope for the cure of cancer of the mouth and larynx.

When I arrived, in Chicago in 1931 I at once instituted this method in the tumor clinic in the Michael Reese Hospital and in my private practice, and when I began my work in the Hines Hospital, I in-



structed the chief of the X-ray department to institute this new method, the details of which I outlined to him.

Now a word about the new technique. In order to have any chance at all of destroying a cancer of the larynx, for example, it is necessary to administer a dose sufficient to destroy the superficial layers of the skin. This reaction produces a moist lesion which looks like an X-ray burn, but it is not a burn because the dose is so finely graduated that the rays destroy the superficial layers of the skin and leave the blood vessels and connective tissue intact, hence the area heals. Generally speaking, when such an effect on the skin is not produced by X-rays or radium it is an indication that the dose is inadequate to cure the cancer. Because the skin effect resembles an X-ray burn, the chief of the X-ray department refused to carry out this technique, claiming that he was legally liable and unprotected.

I would like to, if I may, pass around a photograph, showing the skin reactions. May I do that?

The CHAIRMAN. Yes. The clerk will do that for you.

Dr. CUTLER. This is before and after, the skin at the height of a reaction, and then after they are cured, the two cases.

Here, then, was a new method which, when executed with proper care, was safe, yet without which the cure of cancer of the mouth and larynx was practically impossible. I insisted upon its use in the Hines Cancer unit.

There followed many conferences, both in Chicago and in Washington, and finally I appealed to the medical director and to the Administrator directly. Lawyers from the legal department in central office were finally sent to the Hines Facility to hold conferences on the medico-legal aspects of the problem. At last permission was granted, technicians were trained, and the local radiologists were instructed. The new technique was installed and with it cure of cancer of the mouth and larynx among veterans in the Hines Hospital began to appear.

I have cited this incident in detail because the Veterans' Administration has been criticized recently for its lack of interest in research. Here is an example to the contrary.

In order to make these new advances available to patients in other veterans' hospitals, five subsidiary cancer units were organized to which veterans suffering from cancer could be sent. The parent unit at Hines, Ill., trained most of the members of the staffs of these units in special cancer surgery and in the newer methods of X-ray and radium treatment. At this time one of the trainees in cancer surgery in the veterans' facility, Bronx, N. Y., and the other in the veterans' facility at Sawtelle, Calif., are so outstanding in ability and experience that I look upon them as two of the very leading cancer surgeons in this country.

After 7 years' experience with the newer methods of irradiation, 1931—

The CHAIRMAN. One is at Hines and one at Sawtelle?

Dr. CUTLER. They were both trained at Hines but one is at the Bronx Facility.

Mrs. ROGERS. Did you give their names?

Dr. CUTLER. Dr. Horace Smith, at Sawtelle, Calif.; and Dr. Moreland, at Bronx, N. Y.

After 7 years' experience with the newer methods of irradiation, 1931-37, the results were so encouraging that a further elaboration seemed urgent. In order to execute the new ideas a separate and independent organization had to be formed, and this led to the foundation of the Chicago Tumor Institute in 1938. To organize the surgical aspect of the problem, one of England's great surgeons, Sir G. Lenthal Cheatle, of London, came; and for the X-ray work, Dr. Henry Coutard, of the Curie Institute of Paris, came. Dr. Ludvig Hektoen, one of America's leading pathologists, became president of the institute.

From the very beginning an intimate collaboration was established between the Chicago Tumor Institute and the Hines cancer unit. Sir Lenthal Cheatle, Dr. Coutard, and Dr. Hektoen have visited the Hines cancer unit on numerous occasions, and members of the staff of the Hines unit have visited and observed the work of the C. T. I.—the Chicago Tumor Institute.

I mention this particularly because of the criticism that has been leveled against the Administration of lack of cooperation with other institutions. Here was a work of collaboration, patients are taken by bus daily from the Hines Institute to Chicago for the treatment of cancer.

Here was an incident of collaboration with the chief of the X-ray department of the Curie Institute in Paris; here was collaboration with the great cancer surgeon in London, bearing directly upon the care of the veterans.

The CHAIRMAN. Doctor, would it have been possible for the veterans to have obtained better cancer treatment anywhere else in the world?

Dr. CUTLER. I tried to make it the best.

The CHAIRMAN. Do you think it is the best?

Dr. CUTLER. There is room for improvement. I think it is as good as anywhere.

Mrs. ROGERS. I think the Cancer Control Institute has admitted what a fine record you have there.

Dr. CUTLER. Well, it is the result of the friendly and understanding collaboration. It could not have been attained otherwise.

As newer and more effective techniques were developed, especially for cancer of the larynx, it became imperative to test these methods on earlier and more hopeful cases. That is on what we call operable cases.

The CHAIRMAN. Doctor, before you get onto that, I want to hand you a case, and will you look over it?

Dr. CUTLER. Shall I do that now?

The CHAIRMAN. Yes.

Mr. McQUEEN. Do you want it now or later?

The CHAIRMAN. Right now, while he is talking from these pictures that have been passed around.

Dr. CUTLER. Of course, it is impossible to tell, from looking at the photographs what we are dealing with, but looking at the photograph and reading the letter, it would seem that this patient has had an extensive amount of X-ray treatment and claims he has X-ray burns.

Now, as I look at the photograph, it looks as if there might be some recurrent cancer there too.

I would have to have more of the details to know whether we are dealing with X-ray effect, or cancer and X-ray effect.

The CHAIRMAN. He said he had those treatments at Hines Hospital.

Dr. CUTLER. Yes.

The CHAIRMAN. I thought maybe you were familiar with this.

Dr. CUTLER. No; I did not see this particular patient.

The CHAIRMAN. What effect did the burns have?

Dr. CUTLER. Well, in the first place, there is a good deal of question as to whether this is an X-ray burn. It may be a combination of X-ray effect and cancer.

The CHAIRMAN. I thought probably that was a duplication of the effect you showed in these pictures.

Dr. CUTLER. They look very much alike, the difference being that the lesions of the skin in the picture which I passed around follow within 2 or 3 weeks of treatment.

We know almost to the day when they are going to heal.

The CHAIRMAN. Thank you very much.

Dr. CUTLER. In the beginning the only early cases of cancer of the larynx we treated with X-rays were those in which the operation of removal of the larynx was contra-indicated by some general condition of the patient, such as heart disease or high blood pressure, and those who simply refused to permit removal of the larynx and who preferred to take their chances with the new X-ray treatment. After we had cured a group of such cases we were in position to advise X-ray treatment as the method of choice in certain favorable cases.

Personally, I was convinced that this new X-ray method was superior to surgery in cancer of the larynx which was not too advanced, but in order to prove this highly important point it was necessary to treat an adequate number of comparatively early cases and compare the results statistically with those of surgery.

In this connection I went to Washington and explained the problem to the medical director and to the Administrator with the result that a directive was issued to all veterans' hospitals to send all patients suffering from cancer of the larynx to the Hines cancer unit. This resulted in a concentration of cancer of the larynx in such numbers that this important test could be made for the first time.

In the beginning, before the X-rays staff at the Hines Facility understood the new technique, selected patients were treated in the Chicago Tumor Institute, and as the staff of the Hines unit became more experienced with this method, the treatment is being undertaken more and more by them.

As a result of this collaboration, it was possible in 1944 to publish in the JAMA the results of treatment of a series of 413 cases of cancer of the larynx with 83 percent 3-year cures in the comparatively early cases.

A table here which was published in the journal gives the statistics:

There were 30 very early cases, 20 fairly early, 50 that could be called comparatively early, and 25 out of the 30 early ones, or 83 percent, were well and without disease and with normal voices at the end of 3 years.

The CHAIRMAN. What percentage was that?

Dr. CUTLER. There were 25 out of 30 very early cases, that is 83 percent; and 40 out of the whole group of 50, or 80 percent, well, 3 years, without evidence of recurrence, and with normal voices.

Now, this is the most important contribution for this witness, that no other institution in the world has been able to get together 50 cases.



The largest hospitals in the country will have 2 or 3. Here we had 50 cases. We would have had to wait 10 or 15 years to get that many together in any other organization.

Mr. ALLEN. You mean you did not get cancer patients formerly as early?

Dr. CUTLER. Yes, sir. Out of the 400 cases only 50 were early.

Mr. ALLEN. Is that because people hesitate to consult medical advice?

Dr. CUTLER. It is because cancer has such a reputation that when a patient fears he has cancer, he has fear that he might learn the truth, and he immediately imagines a mutilating operation, and an unsuccessful one, and he does not come.

That, in my opinion, is the most important reason for delay.

When people begin to understand that, if they go early enough, they can cure it without mutilation, we will have more.

Mrs. ROGERS. That is why you introduced the education in it?

Dr. CUTLER. Yes.

Mrs. ROGERS. And do you think that is why they go to Hines Hospital? Because they hear of these cures?

Dr. CUTLER. Definitely. And we are getting more cases there than in any other hospital.

Here, then, is a major contribution to the treatment of cancer which advanced this problem by many years. It was made possible by a combination of factors: The availability of large numbers of cases, intimate collaboration with other institutions, and complete cooperation on all sides. I must add that it would not have been possible without deep personal interest, encouragement, and support of General Hines.

I break many rules, I do not go through channels at times, but I went to General Hines directly because we were concerned with serious problems.

It has been my constant aim to provide for the veterans the very best care in the treatment of cancer at all times, but even this is not enough. The availability of such rich clinical material and the very best of equipment imposes an obligation on all of us for the advancement of medical science is a recognized function of medical organizations, a responsibility which the Veterans' Administration cannot escape.

At no time in these 14 years have I failed to receive the whole-hearted cooperation of General Hines and Dr. Griffith and their staffs as well as the local officials in the Hines Hospital in my efforts to advance the treatment of cancer among veterans and I think it is fair to say that the treatment of cancer in the Hines Hospital compares favorably with that in the leading clinics and university hospitals in this country or abroad.

During the last 3 years members of the medical staff and the construction department of the Veterans' Administration in Washington have been working intimately with the staff of the Hines Hospital, formulating plans for the construction of a 630-bed cancer hospital to be attached to the present Hines Hospital.

The final plans are completed and construction is scheduled to begin at any time. This cancer hospital will embody our latest knowledge in facilities for the diagnosis and treatment of cancer. Advice of leading experts in various departments has been obtained and this unit will undoubtedly constitute the very best in construction equip-

ment to be found anywhere, including provision for 2,000,000-volt X-ray unit.

It goes without saying that far more important than the physical unit is the caliber of the personnel and the organization of the work.

In this connection I want to say that from those deliberations there arose the question of whether or not to put in a 2,000,000-volt X-ray machine.

Now, a 2,000,000-volt X-ray machine has been constructed, but with very few exceptions it has not been used in cancer, and after numerous conferences with men in different parts of the country, authorities, especially on the safety of this apparatus, I recommended to General Hines that the construction of the new hospital be such as to be able to receive this very high-powered unit.

It took concrete walls about 6 feet in thickness, 5 or 6 feet in thickness. I had to convince the general that the apparatus was safe.

I was convinced by the engineers that it was safe, and the final conclusion was to build a unit for that at the Hines Hospital, and after further deliberation probably accept the unit and use it in clinical research.

I will point that out again as an example of the fact that so far as cancer is concerned, we have kept in the foreground of research.

Mr. ALLEN. Would you mind indicating about how expensive this high-powered unit is?

Dr. CUTLER. \$75,000.

The CHAIRMAN. How does an X-ray volt compare with an electric volt?

Dr. CUTLER. It will be 2,000,000 volts.

The CHAIRMAN. Is that equal to 2,000,000 electric volts?

Dr. CUTLER. I think so.

The CHAIRMAN. The largest high-powered line in the United States I think is less than 300,000 volts.

Dr. CUTLER. I am not sure. The highest used so far is 2,000,000 volts.

We are told that we can effect the skin effects.

That, of course, will be very large, and we are planning to use it, of course, with the greatest care.

Mr. ALLEN. But you have actually tried this machine on human beings and it is working?

Dr. CUTLER. It has not been tried on human beings except there has been one report on the human beings so treated, but there has been no comprehensive study for it yet.

Mr. ALLEN. They can take the treatment from that machine and still live?

Dr. CUTLER. Oh, they have to be safe, and they will be safe. The thing is entirely a matter of dosage.

We use the entire backlog of many things—of many years of experience before we make a new step, and this is simply another step, based on experience.

The CHAIRMAN. Doctor, what is the voltage of the machine that is used?

Dr. CUTLER. 400,000.

The CHAIRMAN. So this will be about five times as strong as that?

Dr. CUTLER. Yes.

Mr. HUBER. There is no comparison between this and the so-called Mexican use; that is low amperage?

Dr. CUTLER. Low amperage.

Mrs. ROGERS. What type of case will you use it on first?

Dr. CUTLER. We believe cancer of the lungs. Cancer of the lung is very prevalent and on the increase, the results of surgery are not too good, although there has been tremendous progress in surgery for cancer of the lung.

We believe that is one place this should be tried.

Mrs. ROGERS. You are not using radium much now. This committee helped to get some radium a few years ago.

Dr. CUTLER. Yes. This leads me to speak of some of the deficiencies in the organization and operation of veterans' hospitals as I have observed it during my 14 years' association with it.

The main difficulties that I have encountered revolve almost entirely on the problem of personnel.

(Mr. Allen assumes the chair.)

Dr. CUTLER. The Veterans' Administration has simply not been able to attract to its medical service the very highest type of physicians. I add at once that there are many physicians in the medical service as highly qualified and experienced as can be found anywhere. One great difficulty is related to the regulations of civil service which are not compatible with the free selection of scientific and technical personnel.

It is obvious that the purpose of the medical service of the Veterans' Administration is to give to the veterans the very best possible medical care at all times. It is equally obvious that the standards of medical service are almost wholly dependent upon the training and experience of the physicians who direct and perform the work.

In order to attract physicians of the highest caliber, the medical service must create conditions of work and offer opportunities comparable to those in university hospitals. It must be in a position to offer careers to physicians to give them an opportunity to advance by merit to an adequate income and some degree of security by pension.

Opportunities to work in a scientific atmosphere, under such conditions, free from the worries and hardship of private practice would surely attract to the service many of the best graduates of the medical schools. The present system of selection of personnel through civil service fails totally to accomplish this purpose.

The last quarter century has witnessed unprecedented advances in all branches of medicine, and specialization in various fields has reached an all-time high. New methods and intricate technique are under intensive study and constant change. Hence, it is to be expected that in the postwar period many changes will be encountered. These constantly changing conditions render it essential to reevaluate the medical service and make such service—make such changes as are necessary to maintain the highest standards of service to the veteran.

As a member of the special medical advisory group of the Administrator I have had an opportunity to study this problem in some detail. The following recommendations are based upon my own experience as consultant and upon the study now under way by the special committee:



1. There should be established within the Veterans' Administration a department of medicine and surgery comparable to that of the Bureau of Medicine and Surgery of the Navy, the personnel of which should be appointed without regard to civil-service laws.

2. A greater use of the services of consultants should be made with adequate authority to carry out their responsibilities.

3. There should be established a plan of regional consultants in medicine, surgery, and the major specialists patterned on the Army plan.

These consultants should visit each hospital in the region several times a year.

4. The administrative and medical activities of the hospital should be separated as much as possible in order that the medical personnel may have the time and opportunity to concentrate on the purely medical and scientific aspects of the work.

5. The chief medical officer and the chiefs of the clinical services should be highly qualified for their respective positions.

6. A system of training of interns and residents should be organized comparable to that in university hospitals. There should also be established a system of graduate training in medicine and surgery and the specialties. Only through this means can the medical service of the Veterans' Administration be assured of well-trained and competent medical officers.

7. There should be an upward revision of the compensation schedules for medical officers.

8. The Veterans' Administration must accept its full responsibility toward medical science by continuing to encourage clinical research and thus contributing not only to the better care of the veteran but to medical science in general.

Mr. ALLEN. Are you through with your statement?

Dr. CUTLER. Yes.

Mr. ALLEN. Are you familiar with the bill introduced by Chairman Rankin of this committee with reference to a Medical Corps in the Veterans' Administration?

Dr. CUTLER. In a general way, sir.

Mr. ALLEN. Do you approve of the bill?

Dr. CUTLER. Yes, sir.

Mr. ALLEN. Let me ask you your opinion with reference to managers of facilities.

Do you feel that the managers should be laymen, or should they be doctors?

Dr. CUTLER. That is an administrative problem which I really do not feel qualified to answer.

Generally speaking I feel, naturally, that all medical activities should be supervised by a medical man. I realize the complications and the other side of the problem.

The CHAIRMAN. We are very grateful for your statement, Doctor, and it is a very splendid statement, and it deals with a field that very few of us have any knowledge of. We can always see the very evil effects of cancer, but we know nothing about it, and, as you pointed out, it scares most folks. And I appreciate the fact that the medical profession is educating people to make known those conditions and to seek early treatment.

Any questions from the gentlemen of the committee?

Mr. Domengeaux?

Mr. DOMENGEAUX. I do not have anything.

Mr. ALLEN. Mr. Carnahan?

Mr. CARNAHAN. You have a private practice?

Dr. CUTLER. Yes, sir.

Mr. CARNAHAN. In your opinion, how do you think the veterans' facilities compare with the private facilities, hospitals? Do they compare favorably or unfavorably?

Dr. CUTLER. I believe that the patients—are you speaking of cancer patients?

Mr. CARNAHAN. Yes.

Dr. CUTLER. I would prefer to answer that because I am more familiar.

Mr. CARNAHAN. Yes.

Dr. CUTLER. Why certainly the cancer patient in the Hines receives good care and treatment at the Chicago Tumor Institute, as good as any private patient.

Mr. ALLEN. Mrs. Rogers?

Mrs. ROGERS. Doctor, you mentioned some other hospitals where cancer is treated. Do you feel that they are having the excellent care in these other veterans' hospitals?

Dr. CUTLER. Yes; I believe that the cancer patients in those other units receive very good care.

Mrs. ROGERS. You did not make any investigation after the Deutsch articles, because your specialty is cancer?

Dr. CUTLER. I was asked to go to the Atlanta Facility and look into the cancer work there, and I found it highly satisfactory.

Mrs. ROGERS. They are getting good results?

Dr. CUTLER. Yes.

Mrs. ROGERS. What results do you have with cancer of the eye?

Dr. CUTLER. Of the lid, or the eye itself?

Mrs. ROGERS. The eye itself.

Dr. CUTLER. Well, we have cured those cases with rather remarkable permanent results, cancer of the cornea.

We have treated several of those cases at Hines.

Mrs. ROGERS. Are you treating Hodgkin's disease?

Dr. CUTLER. Yes.

Mrs. ROGERS. Have you any cure for that?

Dr. CUTLER. No; Hodgkin's is very bad.

Mrs. ROGERS. And you feel that one of the contributions the Veterans' Administration has made is in cancer?

Dr. CUTLER. Well, I think it is an example in a special field of one unit, obtaining the adequate treatment, and their personnel is an example of what can be done in other fields in the Veterans' Administration.

Mrs. ROGERS. I gather from your testimony you do not feel just the transfer from General Hines to General Bradley will cure the medical and surgical situation unless that medical department be given power.

Dr. CUTLER. I think in reading these really critical articles, if I may comment on them?

Mr. McQUEEN. Go ahead.

Mr. ALLEN. Yes.

Dr. CUTLER. I should say, I feel that the remarkable thing is not that somebody found a patient who was unhappy about his treatment, the remarkable thing is that so many patients have been treated so well.

There is no medical organization in the world that begins to compare in scope with the Medical Department of the Veterans' Administration, and it is simply amazing what good treatment so many patients have received over so long a period of time. That does not mean there is no room for improvement, and any doctor is constantly looking for methods of improvement, but certainly as I see it, the program, the medical care that the veterans have had, has been very good indeed.

Mrs. ROGERS. You feel then that the promises of care for the veterans have been lived up to?

Dr. CUTLER. I certainly do, and I think that constantly we have to keep our eyes open as to how we can improve them.

Mrs. ROGERS. That is our obligation.

Dr. CUTLER. That is our important obligation.

Mr. CARNAHAN. Doctor, you would not recommend the Government selling the veterans' facilities and allowing the veterans' attention and letting him get his medical treatment wherever he wants?

Dr. CUTLER. I think he would get far less care than he is getting.

Mr. VURSELL. Doctor, in your 14 years in the service and from your knowledge of the work of the organization—the veterans' organizations, I take it that you are of the opinion that in this very large organization with soldiers generally, in all walks of life, we might say in their treatment generally for various diseases, that the work of the Veterans' Administration under General Hines and the present staff has been most commendable?

Dr. CUTLER. Yes, sir; definitely.

Mr. VURSELL. Realizing, of course, that in any great organization of this kind, there will be a certain amount of maladministration, and, because of the lack of help and personnel and with the war on, that that will aggravate the situation, but, notwithstanding that, you would think that the veterans' organization and administration has done a very remarkable job, a remarkably good one, too?

Dr. CUTLER. I think so, and with emphasis on how remarkably well they have been able to do since the war, realizing that they have been loaded with more patients, while at the same time their medical and technical personnel has been taken away from them.

Mr. VURSELL. You think it would be an improvement, I take it, if we could put the appointment of the medical staff on a merit basis and, I might say, on a business basis, in their employment, rather than through the Classification Act and the Civil Service?

Dr. CUTLER. I believe we must have a freer selection of personnel in order to build up the medical and technical staff to a very high caliber, as free as the law will permit us.

Mr. VURSELL. I agree with you perfectly.

Mr. HUBER. Doctor, assuming the Civil Service safeguards are removed, what would you have to effect that?

Dr. CUTLER. I'm not so familiar with that, but the United States Public Health Service seems to have a satisfactory medical department, and I am not thoroughly familiar with that, but I think of that in connection with your question.



(Mr. Rankin resumes the chair.)

The CHAIRMAN. Doctor, would you care to discuss the cause of the growing prevalence of cancer throughout the country? You stated a while ago that it was on the increase, and of course, it has been for some time. Can you give any reason for that increase?

Dr. CUTLER. There are a number of reasons, some of which we think we understand, and others we do not.

One important reason is that we live longer. Penicillin and the other new drugs save us from infection and we live longer, and the longer we live the more likely we are to get cancer, because the incidence of cancer varies with age, and we are more likely to get cancer in our older age.

Second, exemplified by cancer of the lungs. It has been definitely established that there is an absolute increase, not a relative increase but an absolute increase of cancer of the lung, and that came from the Veterans' Administration and was published and it has been quoted in literature and accepted.

Now, the reason cancer of the lung is increased we do not know, but we have some ideas. Some people believe the increase in smoking; others believe gasoline fumes on the streets have something to do with it.

The CHAIRMAN. I read a scientific article some years ago that there was a connection between the increased use of inferior animal products and the increased prevalence of cancer.

Do you agree with that?

Dr. CUTLER. Between what products?

The CHAIRMAN. Dairy products, animal.

Dr. CUTLER. I believe there is no clear evidence on this point, sir.

The CHAIRMAN. No clear evidence.

Dr. CUTLER. But I would like to say the current research on this whole problem of the causation of cancer is taking diet into account very seriously, and it may prove to be that certain things we take in our food—we do not know what those things are, yet—may play a very important part in the development of cancer.

There was at one time a suspicion that certain dyed substances, such as butter yellow used in margarine, might cause cancer and, in fact, the Food and Drug Administration now is looking into that question.

It is all an open problem.

The CHAIRMAN. This article went on to say in those areas where people were largely vegetarians—for instance, I think it probably mentioned an area in the Himalayas—perhaps there was less cancer than where they feed on animal products, like beef and butter.

Mr. SCRIVNER. Well, if beef causes it there will be a considerable drop in cancer.

The CHAIRMAN. I was wondering if that contributed to the causes of the disease.

Mr. SCRIVNER. I have no questions.

The CHAIRMAN. Any other questions?

Mr. CARANAHAN. Is there and development, or tendency on the part of the medical organizations to discriminate against the doctors connected with the Veterans' Administration facilities, so far as membership in the organization is concerned?

Dr. CUTLER. I do not think so. You know of the general feeling of some physicians against socialized medicine, but I do not believe that

goes so far as to express itself in that way. I believe competent doctors are accepted. There may be some exceptions; I do not know.

Mrs. ROGERS. Are you finished?

Mr. CARNAHAN. Yes.

Mrs. ROGERS. Doctor, I infer from your testimony that you did not expect the veterans' hospital to just go into the clinical part of it on cancer cases. Is that right?

You have not made an inspection of all of the hospitals, going right through the hospitals from the very beginning?

Dr. CUTLER. No. I have never been asked to do that.

The CHAIRMAN. Doctor, eating meat from a cow that had tuberculosis, would that cause the person eating it to contract tuberculosis?

Dr. CUTLER. I do not think I am qualified to answer that. Generally speaking as a physician, it has been my impression that that is the case, and that is the reason for the inspections that we have, but I do not think I am qualified to answer that, sir.

The CHAIRMAN. Of course, Public Health Service is in the field of preventive medicine; they are trying to find what causes the various diseases and prevent their spread, the infection.

For instance, 40 years ago, we had a tremendous amount of malaria and typhoid where I live, and in 1905 our Gulf coast was swept with typhoid fever and yellow fever, but due to the genius of Walter Reed, who discovered the cause of yellow fever, we got rid of it, and, as a result of that, they went a step further and found the cause of malaria and then the cause of typhoid. And those three diseases have been practically eliminated.

But I was wondering what is being done in this field of cancer prevention, to stop the spread of that.

Dr. CUTLER. Well, in that field I feel that the medical department of the Veterans' Administration has unequaled opportunity, because they have the largest number of patients under perfect control and therefore a wonderful opportunity for clinical research.

The CHAIRMAN. Does thyroid trouble usually result in cancer?

Dr. CUTLER. No; the general thyroid disease—we think of goiter, for instance—is not related to cancer.

However, there is one, what we call edema of the thyroid, which in numerous instances becomes cancerous.

The CHAIRMAN. It is because of lack of iodine in the food?

Dr. CUTLER. Yes.

Mr. VURSELL. Now, any development of the cancer work in the Veterans' Administration, do you care to say whether you were aided or deterred by the lay manager of Hines Hospital or by the Assistant Administrator, or the Administrator?

Dr. CUTLER. I should say not in the slightest. I have had nothing but help and encouragement from all of them.

Mr. VURSELL. That is all.

Mr. McQUEEN. Along that line, I would like to ask you, Doctor, we will say in the handling of cancer hospitals or cancer centers, would it be your idea that these hospitals should be managed by lay people or medical people?

Dr. CUTLER. I am assuming now you are speaking of a hospital and not associated with any regional office.

Mr. McQUEEN. That is right. Just the hospital.

Dr. CUTLER. Frankly speaking, I do not think that I am qualified to answer it, but in a general way I would say that it depends largely on the individual.

There are some medical men with administrative training who, I think, would be ideal to direct a hospital.

Conversely, a lay director with no knowledge of medicine would be comparatively at a disadvantage.

So, of the two systems, I would say that a medical person with administrative—some administrative experience—I think, would be a better director.

Mr. McQUEEN. Well, would you say that the medical administrator would have to give too much time to the average clinic or hospital to take away from his clinical work in the management?

Dr. CUTLER. That depends entirely on his having enough trained administrative assistants, which would solve that problem at once.

Mr. McQUEEN. The over-all answer would be, it would be more successful if it would be under the absolute direction of the medical man?

Dr. CUTLER. I think that is so, unless there were some administrative problems with which I am not familiar.

The CHAIRMAN. Doctor, may I ask you a question? We have separate hospitals for neuropsychiatrics; we have separate hospitals for the tubercular patients.

Do you think we should have an entire separate hospital for cancer patients?

Dr. CUTLER. Yes, sir. We are planning that, as you know.

The CHAIRMAN. That would enable us to staff that hospital with cancer specialists, would it not?

Dr. CUTLER. Yes, sir.

The CHAIRMAN. And that is what you are driving at at Hines?

Dr. CUTLER. Yes, sir.

The CHAIRMAN. Is that to be under separate management, separate and distinct from the Hines Hospital?

Dr. CUTLER. We have not yet discussed—I have not yet known of any discussion about the details of the organization. I do not know what the plans are.

The CHAIRMAN. Do you think the cancer patient should be separated entirely from other patients and placed in a separate institution?

Dr. CUTLER. Yes, sir; I do.

The CHAIRMAN. Instead of having one great sprawling institution with patients of all kinds in it?

Dr. CUTLER. No, sir; I think there are important advantages to having a separate cancer institution, as proved by the Memorial Hospital in New York, the Institute in Paris, and Stockholm.

The CHAIRMAN. Location does not mean anything in cancer hospitals?

Dr. CUTLER. No, sir.

Mr. HUBER. How about the diagnosis in the early stages? Where one particular hospital might not be able to diagnose it without trained technicians?

Dr. CUTLER. I think it should be the duty of the cancer hospital to give courses in early diagnosis to members of Veterans' staff in other hospitals.



That should be a center of education.

Mr. CARNAHAN. Well, many of your cancer patients have other diseases besides cancer, do they not?

Dr. CUTLER. Yes, sir.

Mr. CARNAHAN. Then you would have to provide for these other diseases?

That is, unless you put on able staffs in all of the major things they have?

Would not your patients get then an inferior grade of treatment for diseases other than cancer?

Dr. CUTLER. In the cancer unit at the Hines Hospital, where we encounter a condition other than cancer, we at once call in a consultant for that condition. If the patient has diabetes, we call in the consultant for diabetes.

That is more satisfactory than having the patient in a general hospital.

The CHAIRMAN. Well, thank you very much, Doctor. You have been very helpful. We are grateful indeed for your contribution.

Dr. GRIFFITH. Dr. Malcolm T. MacEachern, associate director and chairman, administrative board, American College of Surgeons; professor of hospital administration, also associate professor of medicine, Northwestern University; former general superintendent, Vancouver General Hospital; member, committee on hospitals and memorial commission on physical rehabilitation, National Defense Advisory Board; advisory board of American Dietetic Association; advisory council, Association of Medical Social Workers.

#### STATEMENT OF DR. MALCOLM T. MacEACHERN, ASSOCIATE DIRECTOR AND CHAIRMAN, ADMINISTRATIVE BOARD, AMERICAN COLLEGE OF SURGEONS

The CHAIRMAN. Doctor, are you a practicing physician?

Dr. MACEACHERN. No, sir; administrative medicine, I guess, is my field.

The CHAIRMAN. Have you ever practiced medicine?

Dr. MACEACHERN. In a hospital, yes. I was in a hospital for 3 years in which I specialized in that particular field, but I did not practice outside of the hospital.

The CHAIRMAN. What medical school are you from?

Dr. MACEACHERN. McGill, Montreal.

The CHAIRMAN. When did you finish that?

Dr. MACEACHERN. 1910. And I finished my graduate training in 1913.

The CHAIRMAN. Where did you take your literary course, literary schooling, academic?

Dr. MACEACHERN. I took my academic work in Ontario. I was born in Canada and I took it in Canada—McGill.

I am a naturalized American for several years.

The CHAIRMAN. All right, Doctor, you proceed.

Dr. MACEACHERN. My contact with the Veterans' Administration dates from 1924.

I happened to be taken in the American College of Surgeons as an associate director, and my chief work at the beginning was director

of the hospitalization standardization movement for the United States, Canada, and for foreign countries where we had interests:

We are international, in a sense; our organization includes surgeons of North and South America and some foreign countries.

We have 14,000 members who are surgeons who have qualified after 7 years or longer out, and who are recognized surgeons in general surgery or in a surgery specialty.

We set up our qualifications at camp but found that many of our men could not meet that because they did not have the right kind of environment in hospitals to get the right kind of experience, and so, by common consent, we started a hospitalization standardization movement in 1918, which will assure the best diagnosis that treatment—best diagnosis and treatment to every patient who comes in as far as scientific medicine will permit.

That is from setting down certain standards, physical plant, and equipment, organization, personnel, medical staff organization, case records, clinical findings, X-rays, and the like.

When we started this only 89 hospitals had any kind of acceptable organization or laboratories or X-rays, and so it fell our lot to take all hospitals with 25 beds or over and list hospitals as approved.

This was going on a few years and proved successful and General Hines and his group in the Administration asked us if we would make surveys of veterans' hospitals in the United States, as they wanted a disinterested organization beyond their own inspection to get them the facts on what they found, bearing on the care of patients.

So we undertook this. The Veterans' Administration—it was then the Veterans' Bureau—asked us first. That was followed rapidly by the Army and Navy and Public Health Service.

So they are all on our annual survey list as to meeting those basic requirements.

We put on this survey ever since we started our most experienced two men, and we have—in our files at our organization, we have 324 surveys of the 89 hospitals, of the 80 hospitals—the 89 hospitals that have been made, repeatedly, of course.

All that material in files like this [indicating] is available for your committee if they want it.

The CHAIRMAN. How many years does it cover?

Dr. MACEachern. Since 1924. We started the survey in 1924 and have been carrying it to the present time.

And we have made other surveys and very critical ones, and we have sent back to the Veterans' Administration immediately our findings and the criticisms.

We still have to wait for the time when these recommendations are not carried out promptly. We have never on record one instance of where they did not carry out our recommendations.

I will admit that we did not find very many things wrong with them as compared with most civilian hospitals.

At present, we have difficulty getting pathologists and radiologists in every hospital, because they are not obtainable, but the Administration has been trying to keep them up as well as they can.

In 1925 when we finished we found of the 50 hospitals only 14 met the association requirements at that time, but the Veterans' Bureau asked us to wait 6 months before publishing the list.

You see, we make public every year a list of hospitals that meet the requirements in the United States and Canada and it is quite natural we would wait 6 months, because we always give our hospitals 6 months a year—

The CHAIRMAN. You said "meet requirements."

Dr. MACEachern. Yes.

The CHAIRMAN. Meet what requirements?

Dr. MACEachern. We publish a list every year in October—

The CHAIRMAN. What organization?

Dr. MACEachern. The American College of Surgery.

You see, we take the basic requirements, the American Medical takes the educational aspects.

After the first survey, it was necessary to recommend in one letter 28 radiologists and 32 pathologists, and that was back in 1925, and which they filled as quickly as they could.

Coming now to the present situation, during all these years the Veterans' Administration endeavored to maintain competent men.

They developed their nursing staff and dietary staffs and other staffs and laboratories just as well as they could.

We found it was impossible to get the high-powered specialists in hospitals because, as you realize, a stipend of \$3,800 to \$4,200 would not get them.

We recommended, and it was accepted, consultants, men outstanding in their special fields, and that was taken up quite widely.

These were men who were recognized in all the specialties, tubercular, orthopedics, and the like.

It cost the Veterans' Administration a considerable amount of money. Some were on fee basis, some on salary. The fee basis did not work out as well because the consultant was not called, perhaps as frequently as he would have to go, if he was on salary.

In the Chicago area where I live, these men go out and spend 1 day a week.

As we went along the specialists began to go into these long drawn-out cases. They did not present the problems and they were not so interested—they were not so interesting to these high-powered consultants, so therefore, there came a time when their services were not needed as much as when they were running the acute group.

Some say the consultants are not used as much as they should be. Maybe that was the reason. It was a great contribution to the medical service.

Another thing we recommended is not to put the neuropsychiatrics here and the TB here and separate them, get them together in one hospital; and that was done by making it a facility, combining—having the regional office there, too. We felt that in this way they would have the advantage of the specialists, by getting them closer together, there would be a better system of contact—contact and consultation.

Another thing we have recommended on several occasions, and I think it is something everybody is sympathetic to, is that these hospitals in the future should be near the medical centers where the men could go to the medical centers and keep up with the times, and also get into research as much as possible.

Now, in our medical group, the Medical Advisory Group, which you have heard about, and I am not going to repeat too much, it is all



written out here—it fell to my lot to write out the original recommendation of what we would recommend for the Veterans' Administration.

Now, I want you to get this: You are not having this reorganization because of a whole lot of stories which we do not have much knowledge about. You are having it as a trend of the times.

Every major hospital is now getting a new line because of this post-war period. We believe now that all hospitals will have to come into a new level on account of the advances in medicine. Every State in the United States from one coast to the other, there is a survey being made of the State hospitals and the facilities, and there is a Commission sitting on hospitals, headed by the president of the University of Pennsylvania, and Dr. Blackmeyer, of the University of Chicago, is the director of study and they are making a complete study of the hospitals of this country.

In other words, we recognize that we must get on a new level. In the last four years there has been difficulty in every hospital, their personnel has been pulled away, industry offers their personnel bigger salaries, the best doctors were taken away, the best nurses were pulled away. Some were kept home.

But there is not a hospital in this country that has not had its problems in the last 4 years. There is no question that many of their best doctors were taken into the war, and their best nurses.

Now, it is true that was helped by the Army assigning some of their reserve men to the veterans' hospitals. I do not doubt but what these men were disappointed because they had enlisted for service for the acute cases. In the veterans' hospitals most of them were the long-drawn-out cases with very little philanthropic interest. Now, doctors are attracted by one thing, scientific medicine. How I can learn more medicine—how can I improve myself, and, secondly, my salary.

Those two things draw them to veterans' hospitals.

Many of our Army doctors will be disappointed when they have to take on this work. It was something we had to bridge over.

Now, in regard to the administration of veterans' hospitals in the future, our committee discussed the question of the central office having a medical director to be made an assistant director of the Veterans' Administration, and that he be charged with full responsibility to the Administrator for the medical services concerned with the care of veterans.

(Mr. Allen assumes the chair.)

Dr. MACEachern. It is also suggested that his designation be that of Director of Medical Services, United States Veterans' Administration. It is believed by the Medical Advisory Group that there should be established within the Veterans' Administration an organization of the medical services comparable to that of the Bureau of Medicine and Surgery of the Navy, thus giving the medical services of the Veterans' Administration a more definite and recognized status than at present.

Such a Bureau of Medicine and Surgery, or whatever the organization might be designated, would include the Director of Medical Services and the assistant directors in charge of the various professional services—that is, medicine, surgery, tuberculosis, neuropsychiatry, dentistry, radiology, pathology, research, and postgraduate in-

struction—and the liaison officer of the special Medical Advisory Group of the Administrator.

As far as the central office inspection was concerned, the Medical Advisory Group believes that the efficiency of the central office inspection would be increased by more frequent visits of the heads of the various medical and hospital services to the extent of every 6 months or twice a year.

This inspection should involve particularly the medical or professional care of the patients. It might mean the cutting down of the customary period of time now spent on each station and possibly lessening the details of the reports or limiting them chiefly to deficiencies in the service and their remedy. Central office inspection should be regular, thorough, and complete, keeping primarily in mind the quality of the care rendered the patient. For obvious reasons it would be advantageous for the Administrator of the United States Veterans' Administration to visit as many institutions as possible from time to time.

We also recommended regional consultants. The Medical Advisory Group recommends to the Administrator of Veterans' Affairs the establishing of a plan of regional consultants in medicine, surgery, tuberculosis, and neuropsychiatry who are specialists of recognized standing in their respective fields. The proposed plan would follow the pattern of the Army in each service command where there are consultants in the major fields of medicine and surgery.

These consultants would visit each hospital in the region or assigned area at regular intervals, possibly three or four times a year, and remain long enough at the station to see all the cases in his particular service. It is our understanding that this plan is working well in the Army, and we believe it could be applied equally well to the medical service of the Veterans' Administration, provided there is a careful selection of the regional consultants.

This type of regional consultants is very valuable. Now, in addition to the regional consultant, there will be the local consultant—that is, men who can be called on in the community who are probably teachers in the university or who were fellows of the College of Physicians, College of Surgeons or Diplomates of the 15 boards.

These local consultants would be available for certain periods of time at the hospital, preferably a day a week or something like that, and they should be remunerated for it.

In the plan we discussed and which I am interested in, it was provided for the consultants, local and regional. The regional ones who spend sufficient time in the hospitals to cover all the cases which might be in his particular line—his particular specialty in that hospital. That would give the veterans, we feel, the advantage of the very best there is.

We also discussed who shall administer the veterans' hospitals. We felt that there was a movement on—I understand there is a movement on—to separate the regional office from the hospital and this may be accomplished again instead of a facility.

We think that would be a very good move, and that the chief medical officer of the hospital should be responsible to the Director of Medical Services of the Veterans' Administration.

The Medical Advisory Group recommends that the chief medical officer of each United States Veterans' Administration hospital be in



effect comparable in authority to the commanding officer or head of the hospital in the Army and Navy, and be responsible to the Director of Medical Services—or assistant director in charge of medical and hospital services. This officer should be selected with due care as to his professional status in the type of work for which he is prepared—that is, general medicine or surgery, tuberculosis or neuropsychiatry. He should be a well-recognized specialist in the type of work which is carried on within the hospital which he administers. He should have an adequate number of clinical assistants and administrative assistants, depending on the size of the institution. His responsibilities in general would be the entire institution and in particular the professional care of patients, with adequate provision to relieve him of the detail of administrative duties. His time should be conserved for the medical policies and medical services of the institution rather than being taken up with administrative detail.

Now, when we come to the administrative assistants, the Medical Advisory Group recommends that in each hospital one or more competent, trained, administrative assistants be appointed to look after all the administrative details in the management of the hospital working through well organized departments with competent heads for the carrying on of the various activities incident to the care of the patient. Such administrative assistants to the chief medical officer could very well be trained, competent laymen or medical men who have a preference for administrative work rather than clinical. It is essential, however, that such person or persons be properly trained to carry on the administrative duties of the hospital. In this connection, it is learned that there are some 18,000 men in the Medical Administrative Corps of the Army. This could well be a source of supply. These men would need special training for the work and it is suggested that a course or courses of training be set up. Looking forward to postwar needs and at the request of the president of Northwestern University and the dean of the medical school, a program in hospital administration in connection with the school of commerce and in cooperation with the medical school and the university college on the Chicago campus has been in operation for the past 2 years. It is believed that this university would be prepared and willing to give training to a group as suggested who thus might become trained administrative assistants for Veterans' Administration hospitals. There may also be other places where such courses could be given. The Medical Advisory Group believes that this plan would greatly enhance the administrative efficiency of the Veterans' Administration hospitals. These men through a specially prepared institute or longer course could well be organized in the basic principles of hospital organization and management and their practical application to Veterans' Administration hospitals. Such a course or courses would consist of lectures, seminars, conferences, round-table discussions, field trips to other hospitals, and demonstrations. Our group also recommended, and we agree on the thing that the heads of the services in the medical service should be recognized specialists.

The medical advisory group recommends that so far as it is practicable and possible the heads of the various services in Veterans' Administration hospitals should be fellows of the American College



of Physicians, fellows of the American College of Surgeons and/or diplomates of the various American specialty boards now numbering 15, or medical officers of equal standing. There may be found in every community certain highly qualified physicians and surgeons who are not fellows of either of the colleges of diplomates of the boards but who are highly proficient in their respective fields. Through examination or a credentials committee the eligibility of these men could be determined before an appointment is made. However, it is understood that all the medical officers in the Veterans' Administration cannot acquire the standing of recognized specialists, but the younger members of the medical staff should aspire thereto and be encouraged to obtain their recognition in the various fields as soon as prepared. Possibly, after setting up graduate training in general surgery and the surgical specialties and in general medicine and the medical specialties, opportunities for training will be available for the younger medical officers in the Veterans' Administration hospitals so that they can advance into fields of recognized specialties.

We believe that these hospitals are able, in many instances, to have interns and residents. We believe that they should particularly train younger men in 3 to 4 years to grow up into the service to carry on the work. I am going to mention in a minute the plan which we are carrying out now in this respect. We know the veterans' hospitals are now taking on nurses. They have probably 300 or 400 of the cadet nurses. I know Hines has 140 nurses finishing their training, 100 or more cadet nurses and others that come in for evaluation. The veterans' hospital offers excellent training for nurses in that stage. They will have to come perhaps later but they are ready for evaluation and the heads of nursing services that are here today will appear, but what I say is these that are coming here are getting very excellent training in their work. Now, another thing I would like to discuss with you is the fact that we can relieve medical officers of some paper work by a proper system of medical secretaries or dictaphones. We have the same problem in civilian hospitals, only to a much greater degree.

The Medical Advisory Group believes that the medical officers of the Veterans' Administration hospitals have too much paper work under the present system and that the addition of medical secretaries and dictaphones would be most advantageous. There are now trained medical secretaries available. Dictaphones are very helpful in writing medical records. There will be a large number of these machines available after the war and the obtaining of an adequate number for Veterans' Administration hospitals it is believed would not be difficult. At any rate, some plan should be set up within each Veterans' Administration hospital in order to relieve the medical officers of a large amount of paper work thus allowing him more time for his clinical duties.

There are 9 or 10 colleges today turning out medical secretaries for this purpose. We are trying to introduce them in civilian hospitals as fast as we can. A year ago we were asked by the Veterans' Administration to look over a number of their hospitals for the purpose of training in surgery and the surgical specialties. They listed with us some 20 hospitals and we have made a very extensive survey of 20 of

their hospitals to find out how far they could go on a 4-year training in general surgery and surgical specialties and that survey has been completed.

There is a complete report here on these 20 hospitals. They have been surveyed by experts, outstanding men in the field, with a consulting—the consulting services of Major General Reynolds, former major general in the United States Army, who is now on our staff. He and Dr. Ferguson finished 2 weeks ago, going over this 20-hospital group to see in which could be established 4-year courses for the training of younger officers for surgery and the surgical specialties.

Now, according to the statistics of the American Medical, there are 18,000 men coming back when the war is over whose education and training was interrupted; that is, they could not complete their 3 or 4 years' training.

(Mr. Allen assumes the chair.)

Mr. ALLEN. Off the record.

(Discussion off the record.)

Mr. ALLEN. We will have a recess for just a few minutes.

(Short recess.)

(Mr. Rankin resumes the chair.)

The CHAIRMAN. We will proceed. All right, Doctor.

Dr. MACEachern. When we adjourned I was speaking of educational activities in veterans' hospitals. I mentioned to you earlier that the educational standards have increased as medicine has become more complicated. In the Veterans' Administration today and for many years you will find a number of outstanding men. The general consensus of opinion is that men who head departments should be recognized specialists. They may not be always fellows of the colleges or diplomates of the boards but ones with equal proficiencies. It is not possible that all highly qualified physicians and surgeons can take these boards and all that. There are many capable men in the field who are not, but, generally speaking, these are the ones of proficiency, the heads of departments. The younger men should aspire to preparing themselves for the various fields anyway. When the older ones graduated with medical education and years internship and perhaps a year's residence, he was pretty good, but now the young men must look forward to 3 or 4 years' training in the field he desires to enter. The men who have not had that have gained that by long years of experience.

We believe that in the Veterans' Administration now—I believe it—now there will be a better chance for the training of our younger doctors; there will be a chance for intern training—now well established on a definite basis in civilian hospitals; and for graduate training which we speak of as residences.

By that I mean going on new work you want to follow, and then taking 2, 3, 4 years. As I said, the Veterans' Administration called on the College of Surgeons to look over 20 of their hospitals, and that same pattern is established. After the selection of these hospitals they were surveyed by very competent medical men of long experience. They were looked at from the standpoint of training surgeons and training specialists in the various fields of surgery. A report of the finding and summary is here. Two of our staff, Major Reynolds, former major general of the United States Army, and Dr. Ferguson spent



the greater part of a week here with the Medical Director and the heads of divisions, going over carefully each of these hospitals and seeing wherein they were fitted to train for the various fields. And that work has now been completed and we are working with the staff at headquarters in bringing up to the required level for training these different hospitals for different specialties.

Some will take general surgery, some urology, orthopedics, ophthalmology-otolaryngology, and the like. Now, the teaching hospital is better for a hospital in the sense of scientific care of the patient, because you assemble there the groups interested in teaching. Out of your own Veterans' Administration grew the urge to have this training.

Now, the young medical officers coming back from war will want this training and should find the place in the veterans' hospitals. That is the spirit that activated General Hines.

Now, as we survey veterans' hospitals, we make no charge. We assume all costs of this survey.

We have 3,911 hospitals, and we have 3,132 that met the basic requirements. We find when a hospital comes up to basic standards, we do not have to go back oftener than 3, 4, or 5 years. If we hear of any hospital that is not carrying out those requirements, then we go back immediately to that period. We go back naturally to a veterans' hospital if we hear anything about it, and we try to see those as often as possible. It is a critical survey. As I say, they have responded well to it. I remember 2 years ago our representative in his report said, "I do not believe there is good cooperation in the hospital, little teaching, little jealousies, and little cliqueing." I sent this report to General Hines and his staff; they immediately took it up, in fact I had to step in and state that this is not too serious, do not make any trouble over this; but it shows how responsive they were. I am not here to tell you any more than the facts that we find as a disinterested party. All we are interested in is the care for the veterans.

And, while I mentioned the vocational aspect of veterans' hospital, it is because we have a tremendous need; but, also, it is all in the interest of maintaining the kind of staff required there. I have always believed that a medical corps would be a good and valuable thing in the Veterans' Administration. I am very glad to see the bill that is being discussed, and want it to develop. I feel and my conferees feel that you will have to pay more. I have to find men, and where I used to get them for \$5,000 or \$6,000, now they want \$8,000 or \$10,000. Things have taken quite a jump—they have gotten quite an increase in salary.

In our study the other day we found the cost of living was up to 27 percent in that vicinity. I imagine that is true all over. So, therefore, we do have to face the problem of higher salaries in our medical services. Now, with the exception of one of our Medical Advisory Committee, all these men are very smart men. That one is myself. But the Veterans' Administration has the advantage of the best thought and we have been sitting down diligently looking at this problem for several months and we believe and others of you, that the time is at hand where we have to analyze ourselves and see how we are going to meet this big load that is coming back on us. I said it would be well to have facilities close to medical centers. I was thinking of communities where scientific medical personnel are available for consultation and the like. It is true when situated near medical schools there is much



better chance of getting the atmosphere of research and all that. Now, you take where President Truman mentioned Portland, that facility is familiar to me. I was one who helped to locate that hospital. A very distinguished surgeon built it up in the hills. I always told him people would not walk up that hill, but he built that school and he visualized at that time there should be a group of buildings and when the veterans built, they built near that school. Now, the young fellow who is going to learn a specialty or take basic science, if a man is going to be a urologist, he must know the anatomy. And there is pathology. He must learn more about applied pathology.

He must learn more about applied physiology, because that has advanced greatly since this war. You have heard about shock and hemorrhage and all those things, and you must acquire the latest things which are basic. Therefore, in our thinking and in our education today we are talking about applied basic sciences, and the medical schools of this country, I believe, are going to be very sympathetic to a program like this. You know what happened in Minnesota the other day. Our representative said you should set up your graduate program and affiliate with the medical school and the chief surgeon and the dean of medical school said they would cooperate and take the men for basic science for 6 months or a year, and then they have the rest of the 3 or 4 years in the veterans' hospital under supervision. At the end of the time, here is a qualified man to go into the service. Now, a hospital that teaches is a better hospital because of its teaching. So, I think they could do more—the head of the nursing division is here—but they sure graduate training and educational aspects at the hospital.

Now, we are all activated by trying to get into these industries the best we can for these veterans. We have one common purpose, but I must say, I have always felt they were doing a very good job. But, like our civilian hospitals, since the war started we have had lots of problems. Now it is true that you will get things going wrong in any hospital; you will have things wrong in your own home. Things may go wrong. We do want them right. We must give our attention to trained administrators for all of our hospitals. You asked—I was asked—whether it should be a layman or medical man. Well, you cannot compare them with the civil hospitals. A great problem in civil hospitals is to get the money and spend it and budget it, and there is a tremendous business problem; consequently, laymen often get that position because of their business background; but to be successful, they must have a medical director who takes care of the professional side. Now, it is true the medical director sometimes would not have the business side. In our course at Northwestern one has to take that side, too, to get that side. In our course at Northwestern the layman has to take the fundamentals of medicine before he can get his degree. The largest hospitals and teaching hospitals are run by medical men.

In the Veterans' Administration it is strictly a medical problem, and I think the proper plan is to have a competent chief medical officer who is a good clinician and understands the problem of medicine, and give him additional assistants and administrators of the type he needs who have been training. Then you have your professional and administrative set-up all combined and coordinated in a fine way.

The CHAIRMAN. Do you say all veterans' hospitals come up to the standard?

Dr. MACEACHERN. These 20 will come up to the teaching standard just as soon as things are stabilized with the personnel. Ten of them are ready now to give—there are 34 plans in 10 hospitals that are ready now.

The CHAIRMAN. You are speaking now with reference to teaching?

Dr. MACEACHERN. But as far as the standards I am talking about?

The CHAIRMAN. Yes.

Dr. MACEACHERN. All of the 89 hospitals have been approved.

The CHAIRMAN. I thought we had 94.

Dr. MACEACHERN. We have not covered 94.

The CHAIRMAN. All you have covered are up to standard?

Dr. MACEACHERN. All the 89; yes.

The CHAIRMAN. Did you read these attacks on the veterans' hospitals?

Dr. MACEACHERN. Yes.

The CHAIRMAN. What do you think of them?

Dr. MACEACHERN. Well, I never get excited at anything I read unless I can go and see for myself or get a survey made. You can take instances in any hospital and get a good story on it. I do not believe that represented widespread conditions. Another thing, I do not believe anybody is competent to make statements on findings from hearsay but should make a survey and take in the whole picture. I want to know who made the survey and study. There are things to my mind, I cannot always take. Now, I do not care for the authority; I want to know what is back of it all; I want to know if 100 patients in that hospital have the same thing as in the report. Now, they may have found complaints. I do not know but that you can find complaints in any hospital.

Complaints do spread; they get more—everybody enlarges a little on it. Perhaps they state the facts; I do not know. Of course, if there is mistreatment of patients, that is a bad thing. If there are any shortcomings in veterans' hospitals they should be corrected?

The CHAIRMAN. I agree with you.

Dr. MACEACHERN. And when we hear any complaint of any veterans' hospital, we immediately go there to look it over.

Mr. VURSELL. Do I understand this survey is given these hospitals without cost?

Dr. MACEACHERN. Yes; without cost.

Mr. VURSELL. And you have been making this survey for how many years?

Dr. MACEACHERN. Since 1924.

Mr. VURSELL. Since 1924. Now, you found some 20 of them in the very top bracket?

Dr. MACEACHERN. Yes. There should be more.

Mr. VURSELL. And you say that some 89 have been approved. Now, what do we understand the approval carries, what endorsement?

Dr. MACEACHERN. It is the whole book here; I will leave this with you [indicating], but it means they are meeting basic standards of building, equipment, personnel, medical services; they have the nursing services, food services, and sanitation as well as you can get these; they have a set-up that is going to assure good care of patients, that

their death rates are within normal limits, that they are having conferences every week or two weeks for the doctors getting together; that the specimens they get from the operating room are discussed by the group, that the staff keep up with current literature through libraries; and everything that tends to the good care of the patients.

Mr. VURSELL. Now, would you say then that your summation would be that, granting in a large organization like this, there will be some maladministration, due to lack of help, due to war crisis we are in, you would not be able to have just the type of personnel—that on the whole you find the Administration's administration from your survey has done a commendable job generally?

Dr. MACEACHERN. Under the circumstances, I would say it is generally; yes. Those specifically mentioned, I am not prepared to discuss, but all our inspections have been by well-trained men, and I would say yes.

The CHAIRMAN. How do those 89 hospitals compare with other hospitals throughout the country?

Dr. MACEACHERN. I would say there is quite a difference in those hospitals. We talk about other hospitals throughout the country, there are so many of them, there are 1,000 not on our list yet, as meeting basic standards. Of the others we always find a considerable number of deficiencies to correct, except the teaching hospitals, and the large well-known outstanding institutions, so if you want to ask me, very plainly, I will say they compare very, very well. If you would see on my desk the civilian problems compared with the veterans—the fact is, in the veterans' hospitals everything is under control. There are medical men in the hospital 24 hours a day; in our civilian hospitals we cannot get even interns and residents, and many of them are running day and night without a doctor on the ground.

Now, we have not come to the place in civilian hospitals where we can have a resident in every hospital, but in veterans' institutions there is a group of doctors there all the time; they are on the ward all the time; they see their patients all the time.

In our civilian hospitals the doctors come in, make their visits, and go out.

And, of course, a number of the civilian hospitals are outstanding because of their research and teaching and the years of experience; but, taking the average of hospitals, I do not see where the veterans take any second seat to them.

The CHAIRMAN. Doctor, what do you think of the proposition of utilizing private and municipal hospitals in connection with treatment of veterans?

Dr. MACEACHERN. Veterans' service?

The CHAIRMAN. Yes.

Dr. MACEACHERN. You mean using so-called private or community hospitals?

The CHAIRMAN. Yes.

Dr. MACEACHERN. I think it has been done before on the contract plan, has it not? Just how far you can do it now with the civilian hospitals overcrowded and long waiting lists from 60 to 300, I just do not know. You may have some difficulties. I think it is a feasible thing but if you are going to have a large number of patients, 200 to



300 patients, you will have to have a large expansion in our civilian hospitals, and at present they are not taking care of the civilian load in many places.

Mrs. ROGERS. May I ask a question?

The CHAIRMAN. Mrs. Rogers.

Mrs. ROGERS. Doctor, under civil-service regulations, after 4:20 p. m., the doctors are not usually in the veterans' hospital, are they? Under civil-service rules and regulations after 4:30, with exception of the O. D.

Dr. MACEachern. I do not understand what you mean.

Mrs. ROGERS. Under civil service—you know the doctors operate under civil-service rules and regulations?

Dr. MACEachern. Yes.

Mrs. ROGERS. The doctors leave at 4:30 p. m. and after that there is only one doctor on duty except for emergency operation.

Dr. MACEachern. The civil service has 8-hour regulation, you mean? I know I have been in many veterans' hospitals after 5 and 6 at night and found many doctors at work.

Mrs. ROGERS. That is where they live on the reservation?

Dr. MACEachern. Yes.

Mrs. ROGERS. In some of the hospitals doctors are not on the reservation, they cannot get the houses for them, cannot get houses nearby. Doctor, do you inspect the basement and all of that?

Dr. MACEachern. Yes.

Mrs. ROGERS. Have you investigated the abuses?

Dr. MACEachern. Well, we cannot do that except when it is brought to our attention. We have not found anything like that yet. I have seen those reports in the paper.

Mrs. ROGERS. You have not taken the trouble to investigate them.

Dr. MACEachern. I think that would handle them best—you know, you are changing personnel so much that we do not know who you are getting in tomorrow—the best way to handle that is through your administrative set-up. If you have a good administrative set-up it will be done.

Mrs. ROGERS. But if they have not already handled it, what should be done?

Dr. MACEachern. Well, I think there should be an apprentice stage first. If you have a proper plan of personnel management you are going to know that type of person before you take them on; then when you make your job assignment, you should make sure that person knows the job, and that you should follow that person to make sure of the type of employee you have.

One of the things we must have with this new code is the art and science of personnel management. Our best civilian hospitals today are putting in personnel managers. They know the type of employees they are getting, and the different training, and then you must have your personal relations within your group; that is, that you know all the people you have and that they are out for the best interest of the patient. I think it is an administrative set-up and you will make your investigation through machinery set up in the Veterans' Administration, and take such action as is necessary. It may do—it may mean dismissal of the people; it may be some other punishment meted out to them.

That should not occur in any hospital. And if you have good administrative qualities, a good set-up and everything in what we call the art and science of personnel management, and good relations it will not happen very often.

We need that now in these big hospitals. Fundamentally, it is a personnel matter. It should never occur.

Mrs. ROGERS. Thank you, Doctor.

The CHAIRMAN. Are you gentlemen finished?

Mr. SCRIVNER. I have no questions.

Mr. CARNAHAN. I wanted to ask the doctor if he has any comparative figures on cases that reach the court from malpractice as they might come from Veterans' Administration facilities?

Dr. MACEachern. For malpractice?

Mr. CARNAHAN. Yes.

Dr. MACEachern. Do you mean lawsuits?

Mr. CARNAHAN. Yes, lawsuits.

Dr. MACEachern. Well, of course medico-legal cases today are practically settled, all of them, out of court without knowing what happens. Most of the cases are settled because of liability insurance policies. The cases that are not are those cited in the journals from time to time and they are not so many.

Mr. CARNAHAN. How often do you improve or change your rating scale, by which you rate hospitals?

Dr. MACEachern. Every year.

Mr. CARNAHAN. And who arranges such scale?

Dr. MACEachern. No hospital is ever changed in rating without an inspection.

Mr. CARNAHAN. I mean, who sets up the items that makes up your rating scale?

Dr. MACEachern. You mean this [indicating]?

Mr. CARNAHAN. Yes.

Dr. MACEachern. Our organization, of which I am director. And these have been developed over all these years. These are the requirements they must comply with. Then our survey takes things that are not up to date in standards and it goes to the institution and a follow-up letter also goes to the Director of the Bureau, and the recommendations are considered and accepted and if necessary, carried out, always, if they are reasonably right.

Mr. CARNAHAN. Your scale can be applied to an objective?

Dr. MACEachern. Yes.

Mr. CARNAHAN. It is not an opinion of somebody?

Dr. MACEachern. Oh, no. Now, many hospitals like Hines do not have to be inspected every year. We go to them as often as we can. These are going to be set up for educational purposes and are going to be inspected every year because we know—we want to know they are giving the right training.

Mr. CARNAHAN. And in your opinion the very best medical thought that goes into your rating scale?

Dr. MACEachern. Yes. When we started this in hospitals in 89 only on the minimum requirements—they lacked laboratories, X-rays, things the patients should have. Now there are 3,132. It cost us one and three-quarter million dollars in our own—our own surgeons paid out of their own pockets. We do not accept even railway fare.

We have just covered 32 hospitals for the Navy and 10 for the Public Health Service.

Mr. CARNAHAN. Ordinarily, how long does it take for an inspection of an ordinary hospital?

Dr. MACEachern. One or two days after you have made the basic survey.

To make those educational surveys it would take about 3 or 4 days. I want to explain to you that when we go to Hines, for instance, for survey, we have all that information on file [indicating]. We have the physical plant and everything right there before us.

If we went to the Bronx or Los Angeles, we have all the past information, and therefore, when you go there you get down to the essentials of the present time, by virtue of the information you have filed. Going for the first time, it takes longer.

The CHAIRMAN. Any questions? Mr. Domengeaux?

Mr. DOMENGEAUX. Yes. Doctor, you stated you have just completed a survey of some thirty naval hospitals?

Dr. MACEachern. Thirty-two.

Mr. DOMENGEAUX. I assume you have also inspected Army hospitals?

Dr. MACEachern. Yes.

Mr. DOMENGEAUX. How does the veterans hospital compare with the Army and Navy hospitals?

Dr. MACEachern. I would not like to answer that question for fear I would be misunderstood too much. I would say that the Army and Navy—I would say that the Army stands up very excellent, too. And they are much the same in their set-up and all that; and the Public Health Service. The Navy is very fortunate in having such outstanding men that they get through the Navy, they have not had as much difficulty as we have in civilian or other hospitals because of the personnel they have developed.

For educational purposes, they all would come to the same level.

Mr. CARNAHAN. The Army and Navy under the same circumstances have an advantage?

Dr. MACEachern. Yes.

Mr. CARNAHAN. And it is not fair to make that comparison?

Dr. MACEachern. That is the way I would put it.

Mr. CARNAHAN. Doctor, in your survey, is the question of cost per patient per day taken into consideration?

Dr. MACEachern. No. We keep away from the financial aspects of it. All we are interested in is care of the patients.

Mr. CARNAHAN. That is all, Doctor.

The CHAIRMAN. You wanted to ask him some questions, Mr. McQueen?

Mr. MCQUEEN. On this survey, Doctor, of Veterans' Administration hospitals—it covers 89 hospitals—that some of these surveys are as old as 1936 and some as late as 1944. Now, have you regular time you make a survey?

Dr. MACEachern. When we have a hospital we are not sure of we do it every year. Of the hospital we are sure of running along, we do not do it more than every 4 or 5 years, when they are stabilized, we will say. For instance, it would be foolish to make a survey of Johns Hopkins or Massachusetts General every year. We direct our



efforts toward those that are weaker. We have directed our efforts the past year that—to hospitals that do not keep basic standards.

Now, we get statistical and other reports on all these hospitals every year. We get information.

Mr. McQUEEN. Well, that would likewise hold good in Veterans' Administration hospitals? We will say you have not been in since 1936 and you know that that standard is maintained—or, if you made only three examinations since 1935, that hospital stands out.

Dr. MACEachern. I never go to a place where there is a veterans' hospital without making an informal visit. That does not represent our visits.

Mr. McQUEEN. In other words, there are many visits which are not included in it?

Dr. MACEachern. Yes. We have 13,000 outstanding surgeons in this country, or 12,000 about, and they are working in most of these communities and areas. There are meetings of these in every community almost each year, until they stopped the travel, and we gather a good deal of information from other sources.

Mr. McQUEEN. Now, you talked about a regional consultant. Is it your idea that the veterans' hospital system is getting to a point where it should be broken down administratively in regions? Or do you mean that these consultants should be confined to certain areas?

Dr. MACEachern. Well, I had in mind the Army. Now, there are nine service commands. Let us take the sixth survey—the Sixth Service Command. Of course, we have our chief medical officer. Then we have a man in general surgery to travel around, see all the cases; a man in neurology, orthopedics. Now, my idea was you would have a general man in medicine, a general man in surgery, and perhaps in neurology and urology and some of the other specialties. That is in that report [indicating].

Now, for instance, we have discussed perhaps physical medicine and rehabilitation. Each man in his specialty would travel from hospital to hospital. He would spend 3 or 4 days or a week in each hospital. While he was there he would see all the cases in that service.

Mr. McQUEEN. Would you recommend that the Veterans' Administration follow that program, or adopt some similar plan?

Dr. MACEachern. Yes. I would recommend they consider it.

Mr. McQUEEN. Consider it.

Dr. MACEachern. Unless you can—of course, local consultants are excellent men if they will spend enough time in the hospitals.

You cannot expect the doctor and high-grade specialists to spend a whole day in the veterans' hospital for \$25.

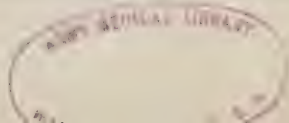
Mr. McQUEEN. No.

Dr. MACEachern. And if he goes to that hospital—I do not like the idea of a consultant to come just for one patient. I would rather the consultant would come to a hospital from outside and see each case of the men in the hospital.

Mr. McQUEEN. Now, Doctor, you spoke of our having 18,000 trained medical administrative men that would soon be released from the Army.

Dr. MACEachern. No; they are in the Administrative Corps. I would not say they are very well trained.

Mr. McQUEEN. They are in the Administrative Corps. Their services will presumably be available?



Dr. MACEachern. Yes.

Mr. McQUEEN. How much of a staff for a 500-bed hospital would it take to have the Administrative Corps to assist the doctors?

Dr. MACEachern. A couple of clinical assistants and a couple of administrative assistants, I would say, offhand, in that 500-bed hospital.

Mr. McQUEEN. In other words, you would say or recommend——

Dr. MACEachern. I would not say that is the exact figure. I would want to know the institution and the ramifications of it.

Mr. McQUEEN. Each hospital should have a sufficient number of men assigned to it to bring it up to what it should be at this time?

Dr. MACEachern. Yes. I do not believe the chief medical officer should have to spend a lot of time going around looking at linen closets and the sanitation and the supply rooms and all that. I think he should give more time for medicine and have an assistant assigned for the physical plant.

And he cannot be expected to visit 500 patients a day, or twice a week. He should have these clinical assistants, administrative assistants, that should go around to the wards on those cases.

The ward officer is there but he is very busy clinically.

Mr. McQUEEN. Do you think that veterans' hospital should be managed then by lay people, from a good administration standpoint, or should they be managed by medical men with the lay people working under them?

Dr. MACEachern. I think the chief medical officer should be the officer in command, so to speak, of the hospital. I believe the Army and some of the other services have the best plan, to have necessary clinical and administrative assistants doing all the routine administrative duties.

Mr. McQUEEN. What do you find in the civilian hospitals?

Dr. MACEachern. In the civilian hospitals today when you have a lay administrator, unless he is well trained, he is not a success, and a lay administrator, to be successful, has to have a medical director or chief of staff, who will spend a lot of time in the hospital because he cannot handle medical problems well with the professional men; he would not attempt to handle the medical problems; and he should surround himself with a medical head and a medical director.

Now, in the veterans' hospital, they have been accustomed in their service ward to a medical man around them, and I doubt if they would have confidence in anyone else. They have depended so long in the ward on that that they will expect that.

I say, give them a chance to work at that and relieve them of the extra duties.

Mr. McQUEEN. Maybe I did not make myself clear. Take the Hines Hospital at Chicago, it is my understanding that the manager of that hospital is a layman.

Dr. MACEachern. Yes; the facility.

Mr. McQUEEN. The facility. But most of the other hospital work has been removed to downtown Chicago. Is that not true?

Dr. MACEachern. Yes.

Mr. McQUEEN. But they still have a manager of that hospital. Do you think that is a proper way to run a hospital, or do you think it should be a medical man?

Dr. MACEACHERN. I think in the Veterans' Administration, because their problem is so much medical, that it should be a medical officer.

Mr. McQUEEN. Now, let me ask you, in your report which you submitted here for us of all the hospitals that you inspect, does that include these osteopathic hospitals, too?

Dr. MACEACHERN. No. Hospitals that are staffed by regular physicians.

Mr. McQUEEN. And does it include any osteopathic hospital?

Dr. MACEACHERN. No.

Mr. McQUEEN. That is all. Now, Mr. Chairman, I would like to introduce these—

The CHAIRMAN. Thank you very much, Doctor?

Mr. McQUEEN. I would like to introduce the Surveys of United States Veterans' Administration Hospitals by the American College of Surgeons, as referred to by Dr. MacEachern.

The CHAIRMAN. Very well.

(The document referred to follows:)

*American College of Surgeons' Surveys of U. S. Veterans' Administration hospitals*

[FA, fully approved; NA, not approved]

Location	Years surveyed	Bed capacity	Present rating
Alabama:			
Montgomery	1941	268	FA
Tuscaloosa	1935, 1942	621	FA
Tuskegee	1930, 1935, 1942	1,665	
Arizona:			
Tucson	1924, 1926, 1927, 1930, 1935, 1942	428	FA
Whipple	1925, 1927, 1930, 1932, 1935, 1942	527	FA
Arkansas:			
Fayetteville	1935, 1939, 1943	258	FA
North Little Rock	1924, 1935, 1940	1,625	FA
California:			
Livermore	1925, 1926, 1929, 1934, 1935, 1942	408	FA
Palo Alto	1924, 1926, 1929, 1934, 1935, 1942	1,417	FA
Los Angeles	1924, 1925, 1926, 1929, 1932, 1936, 1938	2,416	FA
San Fernando	1929, 1934, 1935, 1942	401	FA
San Francisco	1936	340	FA
Colorado: Fort Lyon	1925, 1927, 1930, 1932, 1936	1,026	FA
Connecticut: Newington	1933, 1939	427	FA
District of Columbia: Washington	1925, 1934, 1937, 1943	327	FA
Florida:			
Bay Pines	1934, 1937, 1941	619	FA
Lake City	1924, 1929, 1932, 1935, 1937, 1941	419	FA
Georgia:			
Atlanta	1924, 1934, 1937, 1941, 1942, 1944	415	FA
Augusta	1924, 1930, 1934, 1937, 1941	1,167	FA
Idaho: Boise	1924, 1925, 1929, 1931, 1932, 1936, 1943	203	FA
Illinois:			
Danville	1928, 1931, 1937, 1942	2,300	FA
Downey	1926, 1931, 1937	1,600	FA
Dwight	1936	196	FA
Hines	1924, 1931, 1944	2,029	FA
Marion	1943	214	FA
Indiana:			
Indianapolis	1933, 1937, 1944	345	FA
Marion	1927-1929, 1931, 1937	1,509	FA
Iowa:			
Des Moines	1934, 1939	545	FA
Knoxville	1925, 1928, 1930, 1934, 1939	1,605	FA
Kansas:			
Wadsworth	1924, 1925, 1934, 1940, 1943	742	FA
Wichita	1934, 1936, 1939, 1943	248	FA
Kentucky:			
Lexington	1932, 1935, 1941	663	FA
Outwood	1924, 1939, 1932, 1935, 1941	375	FA
Louisiana: Alexandria	1924, 1926, 1928, 1932, 1934, 1940	739	FA
Maine: Togus	1925, 1926, 1930, 1933	1,234	FA
Maryland: Perry Point	1924, 1937, 1943	1,633	FA



*American College of Surgeons' Surveys of U. S. Veterans' Administration  
hospitals—Continued*

Location	Years surveyed	Bed capacity	Present rating
Massachusetts:			
Bedford	1935, 1939	1,749	FA
Northampton	1924, 1930, 1935, 1939	1,002	FA
Rutland Heights	1924, 1930, 1935, 1939	469	FA
Michigan:			
Dearborn	1942	463	FA
Fort Custer	1924, 1935, 1940	1,723	FA
Minnesota:			
Minneapolis	1931, 1934	786	FA
St. Cloud	1925, 1936, 1941	1,197	FA
Mississippi:			
Biloxi	1934, 1941	208	FA
Gulfport	1936, 1934, 1941	785	FA
Missouri:			
Excelsior Springs	1924, 1931, 1934, 1940	267	FA
Jefferson Barracks	1924, 1931, 1934, 1940, 1944	203	FA
Montana: Fort Harrison	1925, 1930, 1943	184	FA
Nebraska: Lincoln	1931, 1934, 1936, 1939, 1944	379	FA
Nevada: Reno	1936, 1942	26	FA
New Jersey: Lyons	1934, 1938	1,925	FA
New Mexico:			
Albuquerque	1932, 1935, 1942	313	FA
Fort Bayard	1925, 1927, 1930, 1935, 1942	305	FA
New York:			
Batavia	1936, 1944	295	FA
Bath	1931, 1937, 1944	428	FA
Canandaigua	1933, 1937, 1944	1,275	FA
Castle Point	1924, 1931, 1936, 1944	625	FA
New York City	1924, 1938, 1945	2,090	FA
Northport, Long Island	1940, 1945	2,685	FA
Saratoga Springs	1944	47	NA
Sunmount	1924, 1931, 1933, 1936, 1944	589	FA
North Carolina: Oteen	1924, 1930, 1934, 1938, 1944	1,269	FA
North Dakota: Fargo	1930, 1933, 1936, 1941	159	FA
Ohio:			
Brecksville	1941	285	FA
Chillicothe	1924, 1927, 1935, 1941	1,860	FA
Dayton	1932, 1935, 1937, 1943, 1944	1,077	FA
Oklahoma: Muskogee	1924, 1931, 1934, 1936, 1939, 1943	428	FA
Oregon:			
Portland	1932, 1936, 1938, 1943, 1945	623	FA
Roseburg	1936, 1943	566	FA
Pennsylvania:			
Coatesville	1936, 1941, 1945	1,728	FA
Pittsburgh (Aspinwall)	1933, 1936, 1944	1,134	FA
South Carolina: Columbia	1934, 1937, 1942, 1944	606	FA
South Dakota: Hot Springs	1924, 1925, 1927, 1931, 1936, 1941	276	FA
Tennessee:			
Memphis	1924, 1930, 1932, 1935, 1941, 1942, 1944	565	FA
Mountain Home	1924, 1929, 1932, 1934, 1937, 1941	553	FA
Murfreesboro	1941	1,007	FA
Texas:			
Dallas	1941	352	FA
Legion	1925, 1930, 1935, 1940	409	FA
Waco	1935, 1938, 1940	1,394	FA
Utah: Salt Lake City	1936, 1943	204	FA
Vermont: White River Junction	1939	188	FA
Virginia: Keoughman	1924, 1925, 1930, 1932, 1938, 1943, 1944	528	FA
Washington:			
American Lake	1924, 1926, 1930, 1936, 1943	789	FA
Walla Walla	1929, 1936, 1943	421	FA
West Virginia: Huntington	1937	321	FA
Wisconsin:			
Mendota	1938	282	FA
Wood	1925, 1927, 1932, 1935, 1938, 1942, 1944	1,403	FA
Wyoming:			
Cheyenne	1936, 1939, 1943	212	FA
Sheridan	1925, 1927, 1930, 1936, 1943	594	FA
Total hospitals			89
Total beds			68,925
Total surveys			324

Mr. McQUEEN. I would like to introduce this Manual of Hospital Standardization in the record.

The CHAIRMAN. Very well.

(The bound manual referred to was filed with the committee.)

Mr. McQUEEN. I would like to introduce this report on the 20 hospitals surveyed for teaching purposes.

The CHAIRMAN. All right.

(The bound report referred to was filed with the committee.)

The CHAIRMAN. The committee will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 4:40 p. m. the committee adjourned to 10 a. m. of the following day.)

## AMERICAN COLLEGE OF SURGEONS—MANUAL OF HOSPITAL STANDARDIZATION

(In compiling the subject matter of this Manual of Hospital Standardization, frequent reference has been made to authoritative statements from Hospital Organization and Management in respect to many of the phases presented. Grateful acknowledgment is made to the author, Dr. Malcolm T. MacEachern, and to the publishers, Physicians' Record Co., Chicago.)

### HISTORY, DEVELOPMENT, AND PROGRESS OF HOSPITAL STANDARDIZATION

The American College of Surgeons, founded in 1913 by surgeons of the United States and Canada, is the originator of hospital standardization. The desire of the college to advance the practice of surgery was directly responsible for the beginning of this movement. In order that surgery might be placed on a higher, more ethical plane, the college established as one of the major requirements for admission to fellowship that each candidate submit 100 medical records of patients upon whom he had operated, as evidence of surgical judgment and technical ability. Few candidates, however, could comply with this requirement inasmuch as hospitals in the United States and Canada seldom kept records which provided accurate data. It was also discovered that the average hospital lacked laboratory, X-ray, and other essential diagnostic and therapeutic facilities necessary to the surgeon in making a proper preoperative study of his patient. Furthermore, medical staffs of hospitals were not organized and the professional work generally lacked supervision; most hospitals were deficient from the standpoint of scientific efficiency. The need for improvement was evident.

After several years of preliminary study and investigation, which included surveys of many hospitals and consultations with eminent authorities and officers of national organizations, the epoch-making program in hospital and medical history, known as hospital standardization, was inaugurated in 1918. This program, sponsored and financed by the American College of Surgeons, was received with interest beyond all expectation by the hospitals of the United States and Canada. The growth of the movement has been constant and substantial and now its influence extends to foreign countries, where many institutions are applying the principles advocated, which insure efficient and scientific care of the patient. There are now, at the close of the twenty-second annual survey, more than 44,000 reports on file which show definite and encouraging evidence of progress by hospitals in the fulfillment of their obligations to their ill and injured patients.

### *Hospital standardization defined*

Hospital standardization is a movement to encourage all hospitals to apply certain fundamental principles for the efficient care of the patient which are set forth in the minimum standard for hospitals. Its object is to promote better hospitalization in all its phases in order to give the patient the greatest benefits that medical science has to offer. Throughout the history and development of hospital standardization a definite theme has been sounded, namely, the proper care of the sick and injured. Its aim is to create in the hospital an environment which will assure the best possible care of the patient. What this means to hospital progress is apparent when one realizes that the standardization program requires that each hospital which qualifies for approval shall have an organized, competent, and ethical medical staff; that the staff shall hold regular conferences for review of the clinical work; that fee-splitting shall be prohibited; that

accurate and complete medical records shall be written for all patients treated; and that adequate diagnostic and therapeutic facilities, including a clinical laboratory and X-ray department, shall be provided. This involves facilities, personnel, and procedures predicated upon efficient organization, progressive management, and competent personnel imbued with a scientific and humanitarian spirit. When an institution adopts and successfully applies the above-named principles, which express the high standards of modern medical and hospital practice, it is known as a standardized or approved hospital. These fundamental principles, which are readily adaptable to all institutions caring for the sick, are embodied in the minimum standard for hospitals which is printed below.

#### MINIMUM STANDARD FOR HOSPITALS

1. That physicians and surgeons privileged to practice in the hospital be organized as a definite medical staff. Such organization has nothing to do with the question as to whether the hospital is open or closed, nor need it affect the various existing types of medical staff organization. The word "staff" is here defined as the group of doctors who practice in the hospital inclusive of all groups, such as the active medical staff, the associate medical staff, and the courtesy medical staff.

2. That membership upon the medical staff be restricted to physicians and surgeons who are (a) graduates of medicine of approved medical schools, with the degree of doctor of medicine, in good standing, and legally licensed to practice in their respective States or Provinces; (b) competent in their respective fields; and (c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatsoever, be prohibited.

3. That the medical staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide (a) that medical staff meetings be held at least once each month; (b) that the medical staff review and analyze at regular intervals their clinical experience in the various departments of the hospital, such as medicine, surgery, obstetrics, and the other specialties; the medical records of patients, free and pay, to be the basis for such review and analysis.

4. That accurate and complete medical records be written for all patients and filed in an accessible manner in the hospital, a complete medical record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, X-ray, and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and microscopical pathological findings; progress notes; final diagnosis; condition on discharge; follow-up; and, in case of death, autopsy findings.

5. That diagnostic and therapeutic facilities under competent medical supervision be available for the study, diagnosis, and treatment of patients, these to include at least (a) a clinical laboratory providing chemical, bacteriological, serological, and pathological services; (b) an X-ray department providing radiographic and fluoroscopic services.

The principles of the minimum standard for hospitals are the same today as when the standard was originally formulated in 1918. Therefore, it cannot be said that more hospitals are meeting the requirements at present because of a lowered standard. Hospitals have progressed not only because the public has demanded better service but because hospital standardization has aided in the establishment of a proper environment for the physician, his associates, his assistants, and his coworkers so that they may render to every patient the most scientific service which is possible.

#### *Spirit of hospital standardization*

Hospital standardization contemplates that hospitals by meeting the minimum requirements shall be standardized insofar as the fundamental principles or essentials of efficient hospital care of the patient are concerned. It is not the intention, however, that hospitals by adhering to minimum standards shall be deprived of their individuality. On the contrary, the minimum standard for hospitals has in actual practice promoted independence in adaptation of the standard to varying conditions, and every hospital is encouraged to seek individual growth and development. The fundamental idea is that the individuality of the hospital must be conserved.



While the scientific aspect of the present day hospital is most important, it must not completely overshadow the humanitarian spirit of the institution. The patient in a hospital is an individual, and, therefore, he cannot be standardized. Rather, he must be individualized in diagnosis and treatment, and he must never be considered as an inanimate number or merely as one of a group. He must be received, treated, and discharged not according to iron-clad routinism but according to the requirements of the individual case. Hospitals are learning the important lesson that in order to achieve their purpose of providing adequate care for the sick and injured they must be prepared to give humanitarian service as well as scientific service.

It is entirely possible for a hospital to be both standardized and individualized, both scientific and humanitarian. Hospital standardization makes it possible for an institution to express a distinct personality. The very spirit of the movement is intended to encourage each institution in individual growth so that it may render an efficiently standardized and scientific service made even more effective by a genuine attitude of individualized humanitarianism.

#### *Important aspects of hospital standardization*

The sponsors of hospital standardization believed that through improving the organization of hospitals, and with proper utilization of existing facilities and personnel, much could be done to better the quality of service rendered to the patient.

Hospital standardization is not dependent on any legal endorsement whatsoever, that is, no institution is compelled by law to adopt the principles advocated or to incorporate them in its constitution. Acceptance and maintenance of the minimum standard for hospitals are entirely optional. The worthiness and value of hospital standardization have been manifested by its wide and voluntary acceptance, by its rapid growth and development, and by the increased esteem which is accorded those institutions which have adopted the standard. Few hospitals have been unable to maintain the requirements after they have adopted the principles and applied them with diligence and sincerity. They have found that the adoption of the minimum standard for hospitals has led to more rapid development and higher standards than were previously attempted.

Hospital standardization is not limited to any one part of the hospital; it is not restricted to any one group; it is not confined to any one locality, but it is equally applicable to all hospitals which manifest a true desire to focus every phase of their organization and service on the proper care of the patient. Experience has proved that this can best be accomplished through applying the minimum requirements as described in detail in the text to follow. These requirements are fundamental to sound organization and proper coordination within the hospital in rendering scientific and efficient service to the sick and injured.

#### *Growth of hospital standardization*

The first group of hospitals to be surveyed comprised institutions of 100 beds and over. Commencing in 1918, 24 annual surveys have been made. Remarkable progress in the growth of approved hospitals in this class has been shown. Between the years 1918 and 1941 the number of approved hospitals of 100 beds and over increased from 89 to 1,928. In 1918, only 12.9 percent of hospitals in this class met the minimum standard for hospitals. In 1941, 93.0 percent met the requirements and were on the approved list. A summary of the surveys of hospitals for each year from 1918 to 1941 inclusive is given in table I.

In 1922, the American College of Surgeons began its surveys of the next group of hospitals, those of 50 to 99 beds. Already 20 annual surveys have been made of these hospitals, and while the increase in the number meeting the requirements has not been so rapid as in the group of hospitals of 100 beds and over, it has been most gratifying. At the end of the 1941 survey, 738 hospitals in this group, or 68.2 percent of the 1,082 hospitals which were surveyed, were approved.

In 1924, the survey was extended to include all hospitals of 25 to 49 beds. The hospitals of this group have many difficult situations to overcome since they are sometimes deprived of close affiliation with the larger institutions. However, the high standard which many of these institutions maintain despite physical, financial, and personnel handicaps is commendable. The managements deserve encouragement in their efforts. Up to the present 18 annual surveys of this group of hospitals have been made, with the result that 207, or 38.8 percent of the hospitals surveyed, are approved.

In 1925, at the request of the United States Veterans' Administration, a survey was undertaken of all veterans' hospitals in the United States. In the same

year similar requests were received from the United States Public Health Service, the Army, and the Navy. Seventeen annual surveys have been completed, with the result that 171, or 93.0 percent of the hospitals surveyed, are approved.

The number of hospitals surveyed has increased more than five times, and the percentage of approved institutions of 25 beds and over has increased from 89 or 12.9 percent in 1918 to 2,873 or 77.9 percent in 1941. It is interesting to note that progress in meeting the requirements for approval has been steady and continuous. It is believed that the time is not far distant when only hospitals which meet the minimum requirements for approval will attempt to care for the sick and injured.

TABLE I.—*Surveys of hospitals, 1918 to 1941*

	100 beds and over			50 to 99 beds			25 to 49 beds			U. S. Government hospitals			Summary, 25 beds and over		
	Surveyed	Approved	Percent	Surveyed	Approved	Percent	Surveyed	Approved	Percent	Surveyed	Approved	Percent	Surveyed	Approved	Percent
1918	692	89	12.9										692	89	12.9
1919	692	198	28.6										692	198	28.6
1920	692	407	58.8										692	407	58.8
1921	761	573	75.3										761	573	75.3
1922	812	677	83.4	812	335	41.3							1,024	1,012	62.1
1923	870	751	86.2	916	430	46.9							1,786	1,181	66.1
1924	961	831	86.5	973	508	52.2	307	49	15.9				2,241	1,388	61.9
1925	995	879	89.3	952	535	56.2	327	60	18.3	100	90	90.0	2,274	1,474	65.7
1926	1,055	975	92.4	991	578	58.3	358	66	18.4	95	92	96.8	2,404	1,619	67.3
1927	1,103	1,007	91.2	975	584	59.9	376	85	22.6	98	98	100.0	2,455	1,676	68.2
1928	1,204	1,121	93.1	941	587	62.2	491	89	18.1	97	97	100.0	2,636	1,797	68.1
1929	1,334	1,245	93.3	974	616	63.2	547	108	19.7	95	95	100.0	2,855	1,969	68.6
1930	1,433	1,334	93.1	1,001	596	59.5	730	133	18.2	101	101	100.0	3,164	2,063	65.1
1931	1,479	1,380	93.3	1,034	625	60.4	806	153	18.9	109	109	100.0	3,319	2,158	65.0
1932	1,565	1,469	93.9	1,035	648	62.6	864	177	20.5	116	116	100.0	3,464	2,294	66.2
1933	1,603	1,505	93.9	1,044	659	63.1	907	220	24.2	116	116	100.0	3,554	2,384	67.0
1934	1,649	1,560	94.6	1,050	692	65.9	839	228	27.2	118	118	100.0	3,538	2,480	70.0
1935	1,703	1,614	94.8	1,047	689	65.8	815	220	27.0	135	135	100.0	3,565	2,523	70.8
1936	1,745	1,644	94.2	1,049	708	67.5	775	225	29.0	148	148	100.0	3,569	2,577	72.2
1937	1,787	1,674	93.7	1,045	713	68.2	743	234	31.5	151	151	100.0	3,575	2,621	73.3
1938	1,850	1,726	93.3	1,063	721	67.8	683	217	31.8	159	155	97.5	3,596	2,664	74.1
1939	1,907	1,780	93.3	1,064	731	68.7	593	209	35.2	165	159	96.4	3,564	2,720	76.3
1940	1,986	1,853	93.3	1,088	742	68.1	603	211	35.0	173	163	94.2	3,677	2,806	76.3
1941	2,072	1,928	93.0	1,082	738	68.2	534	207	38.8	184	171	93.0	3,688	2,873	77.9

#### *Other countries interested in hospital standardization*

The interest of other countries in hospital standardization continues to grow from year to year. It may be truthfully said that this interest is manifesting itself in a substantial manner, for in the list of approved hospitals announced in the October 1939 Bulletin there will be found the names of a number of hospitals beyond the continental boundaries of the United States and Canada. It is quite logical to believe that this interest will increase in the future.

Hospital standardization has made itself felt in Australia, New Zealand, South America, Cuba, Newfoundland, and China. In 1926 at the request of the governments of Victoria in Australia, the Dominion of New Zealand, and the British Medical Association of Australia and New Zealand, the associate director of the American College of Surgeons and director of hospital activities was loaned to make a survey of their hospitals and advise with them regarding future policies and developments. While there, he made a survey of the hospitals and assisted the authorities in laying the foundation for the reorganization of their hospital systems along the lines laid down by the minimum standard for hospitals of the American College of Surgeons. Noteworthy progress has been made by both countries since his visit. Significant, also, is the fact that hospital standardization had a prominent place on the program of the 1929 and 1936 congresses of the Pan-Pacific Surgical Association at Honolulu, when its principles were discussed at length by delegates from the countries represented.

#### *Services*

The hospital information and service department of the American College of Surgeons has access to more than 44,000 reports of surveys, the largest single accumulation of actual findings dealing with hospitals. This department, there-



fore, which is coordinated closely with that of hospital standardization, is of distinct advantage to hospitals, inasmuch as through this channel hospitals may secure the most authoritative and complete information available concerning various phases of administration. All requests for information are complied with promptly. The data submitted are selected and arranged in so concise and comprehensive form that the reader is able to glean the required information in the briefest possible time. No charge is made for this valuable service.

In order that the hospital information and service department may aid in the advancement of efficient hospitalization, it carries on the following activities:

1. Makes studies and investigations of different phases of hospital service.
2. Loans carefully compiled package libraries and abstracts of hospital literature on any particular subject or problem.
3. Answers specific questions through correspondence.
4. Organizes and catalogs hospital facilities in metropolitan areas for the purpose of assisting hospital executives in making observation tours.
5. Stimulates increased efficiency in hospital planning and construction, equipment, organization, administration, and service.

Sectional meetings of the college and the hospital standardization conference of the clinical congress provide additional information pertaining to hospital problems. Each of the sectional meetings devotes 3 days to a discussion of hospital problems pertinent to the individual locality. The 4-day hospital standardization conference is an important part of the annual clinical congress of the college. The presentation of papers, demonstrations, symposia, and round-table conferences contribute largely to the instructive nature of the conference.

An institution is entitled to all possible assistance from the American College of Surgeons when it accepts the requirements of hospital standardization. This includes the services of the field representative in helping solve problems so that the hospital may qualify for a place on the approved list. Although advice and assistance may come from the college, action can be taken only by the hospital. The college cannot participate in disciplinary measures or problems which are distinctly individual or local in nature; such matters must be adjudicated by the parties who are concerned with them.

#### *Procedure*

Plans for the annual survey of hospitals in the United States and Canada are made at the beginning of each year, and all institutions eligible for survey are carefully considered. To accomplish this work the college maintains a permanent staff of competent field representatives, graduates of approved medical schools, who possess a thorough knowledge of hospital administration in all its phases and who have had an extensive training in clinical work. They are selected on the basis of character, personality, tact, diplomacy, industry, honesty, and ability to meet the public.

In January of each year the annual field survey is begun. Certain definite steps are followed:

1. Information for registration of the hospital is secured according to a prescribed form.
2. An itinerary of the State or area to be surveyed is carefully planned in order to save as much time and expense as possible for the field representative.
3. Prior to survey, the college sends a letter to the superintendent of the hospital announcing the coming of the representative, purpose of his visit, and data he will wish to review.
4. The representative of the college notifies the hospital superintendent as to exact time of his arrival.
5. The representative makes a thorough, impartial survey according to an orderly, well-established plan, records his findings on a prescribed form, secures reports and other data, and confers, if it is so desired, with the governing board, the medical staff, and others interested.
6. The representative confers with the superintendent or other authorized officers at the close of the survey in order to discuss findings, particularly conditions needing remedy, following which he completes and mails the report to headquarters.
7. The surveyor's report is forwarded to the hospital department and a follow-up letter is sent the superintendent of the hospital with such constructive suggestions or recommendations as are warranted.
8. A close follow-up is kept on the hospitals which are required to correct any deficiencies.

In addition to the surveyor's report there are other sources from which information pertaining to a hospital is secured, such as members of medical staffs;



medical societies; fellows of the college; national, State, and local medical, nursing, and hospital organizations.

A hospital is graded according to one of three ratings:

1. "Fully approved": The hospital having met all the requirements is carrying them out in an acceptable manner.
2. "Provisionally approved": The hospital having accepted the requirements is endeavoring to put them into effect but for lack of time or other acceptable reasons has not been able to do so in every detail.
3. "Not approved": The hospital has not met the requirements in an acceptable manner.

If problems temporarily affect the eligibility of a hospital at the time the approved list is published, the rating of that particular institution may be deferred for further information and observation. The certificate of approval is granted to an institution which has been fully approved for a time sufficient to guarantee its continued meeting of the requirements.

Each hospital is considered for rating annually. An institution once approved will not necessarily always remain so. All hospitals automatically come off the approved list on October 1 and are immediately reconsidered for new rating. At the hospital standardization conference in October of each year public announcement is made of the fully approved and provisionally approved hospitals in the United States, Canada, and other countries.

#### *Advantages of hospital standardization*

It is frequently asked, "What are the advantages in having a hospital on the approved list?" A few of the advantages may be briefly mentioned:

1. To the patient: The patient is assured efficient care through better medical staff organization, competent personnel, and adequate diagnostic and therapeutic facilities. The writing of medical records, the examination and study of pathological specimens, the regular review and analysis of the clinical work, and many other procedures of detail and precision assure a more accurate diagnosis and efficient treatment for the patient. All this means speeding up treatment through shortening the day's stay in the hospital, reducing complication, and, what is more important, lowering the mortality rate. This is desirable for the patient's future comfort and health and is beneficial as well to his economic status.

2. To the physician: The approved hospital provides the physician with a proper environment in which to work. He has not only the necessary facilities at his disposal, but also a well-trained staff to assist him. Through recording the history of his patient, proper use of the diagnostic and therapeutic facilities, the medical staff conference, the clinicopathologic conference, and other features made available in the approved hospital, the physician is able to give better care to his patient, and, in addition, because of organized and systematized efforts, he is constantly improving his armamentarium of scientific knowledge. And, finally, his own professional status is improved by being a member of the medical staff of an approved hospital.

3. To the hospital: The hospital finds it an advantage administratively, socially, and economically to be a standardized institution. Standardization means a more complete and efficiently functioning organization as a whole. The minimum standard provides the hospital with fundamental principles pertaining to the best plan for assuring good professional care to patients. The carrying out of these principles gives better assurance that the administration is functioning in a manner which best fulfills its purpose.

4. To the intern and the nurse: The approved hospital, because of its organization, equipment, and personnel, affords the intern and the nurse better supervised experience. Further, it is essential that such experience be obtained in approved hospitals in order to facilitate registration in most States. To this end it is now customary for nurses and young graduates of medicine to seek information as to which hospitals are approved.

5. To the community: In most instances, the community is directly or indirectly interested in its hospitals. Indeed, every community should have a certain amount of pride in its institutions caring for the sick. The fact that they are living up to universally acknowledged and accepted standards of professional organization and service should be a source of confidence and pride to the community. Indeed, many people requiring hospitalization today seek the approved hospital knowing that it is organized so as to give adequate care and efficient service to the sick and injured.

## DETAILED EXPLANATION OF THE MINIMUM REQUIREMENTS

*Fundamental Principles Upon Which the Minimum Standard for Hospitals Is Based*

1. A modern physical plant, free from hazards and properly equipped for the comfort and scientific care of the patient.
2. Clearly stated constitution, bylaws, rules, and regulations setting forth organization, duties, responsibilities, and relations.
3. A carefully selected governing board having complete and supreme authority for the management of the institution.
4. A competent, well-trained executive officer or administrator with authority and responsibility to carry out the policies of the institution as authorized by the governing board.
5. An adequate number of efficient personnel, properly organized and under competent supervision.
6. An organized medical staff of ethical, competent physicians for the efficient care of the patients and for carrying out the professional policies of the hospital, subject to the approval of the governing board.
7. Adequate diagnostic and therapeutic facilities with efficient technical service under competent medical supervision.
8. Accurate and complete medical records, promptly written and filed in an accessible manner so as to be available for study, reference, follow-up, and research.
9. Group conferences of the administrative staff and of the medical staff to review regularly and thoroughly their respective activities in order to keep the service and the scientific work on the highest plane of efficiency.
10. A humanitarian spirit in which the best care of the patient is always the primary consideration.

The minimum requirements of hospital standardization were formulated, not according to arbitrary rulings but as a result of the study of actively operating institutions, and were designed for the express purpose of providing safe and adequate care for the sick and injured. Experience has shown that the minimum requirements benefit the hospital by increasing the confidence of the community in the institution as a place in which scientific treatment may be received. It is possible for all hospitals to attain this standard; indeed, hundreds of institutions are now exceeding the minimum requirements in the service they render to patients, and hundreds of institutions have been benefited by their efforts to keep pace with the widespread movement for the improvement of hospitals.

In the following pages the five clauses of the minimum standard for hospitals are explained in detail so far as their application is concerned in all institutions caring for the sick and injured, whether general or highly specialized in nature, without regard for size or type. They may be applied with equal success to the large teaching hospital with its highly specialized medical staff conducted as a unit of a medical school in a large city, or to the small community or church hospital located in a small village where there are only a few general practitioners of medicine. The tuberculosis sanitarium, cancer hospital, or institution for the care of mental and nervous diseases, operated by a Government agency with its specially trained staff, or the small hospital privately owned either by an individual or an industrial corporation, may adopt the principles of hospital standardization with the assurance of increasing the scientific efficiency of the hospital.

These principles are applicable and adjustable to varying local conditions which affect the ownership and control of the institution and its service to the community. The intent and ultimate objective of hospital standardization are actually to establish in the hospital an environment in which every practitioner of medicine can carry on his work in such a manner as will be conducive to assuring accurate diagnoses and efficient therapies in order that every patient who enters the hospital may be returned to normal health and production, if possible, in the shortest time and most comfortable manner.

## CLAUSE I OF THE MINIMUM STANDARDS FOR HOSPITALS

That physicians and surgeons privileged to practice in the hospital be organized as a definite medical staff. Such organization has nothing to do with the question as to whether the hospital is open or closed, nor need it affect the various existing types of medical staff organization. The word "staff" is here defined as the group of doctors who practice in the hospital inclusive of all groups, such as the active medical staff, the associate medical staff, and the courtesy medical staff.



*Definition of medical staff*

The medical staff of a hospital is defined as an organized body composed of all physicians who are privileged to work therein. Every physician admitted to practice in the hospital should qualify for membership on the medical staff by submitting an application in writing on a prescribed form (addendum V, pp. 104-105). If acceptable, the applicant is formally appointed by the governing board and assigned definitely to one of the groups which may be designated as—

1. Honorary medical staff.
2. Consulting medical staff.
3. Active medical staff.
4. Associate medical staff.
5. Courtesy medical staff.

Various other subdivisions of the medical staff may be used.

Organization of the medical staff varies from the simplest type of the undifferentiated group, which is often found in small hospitals where specialization is not developed to any extent, to the highly departmentalized medical staff existing in the large teaching hospitals (addendum III, p. 102).

*Definition of "open hospital"*

An "open hospital" is one in which there is an attending or active medical staff responsible for the treatment of charity cases, but which permits other physicians—generally known as the courtesy medical staff—to utilize the private-room facilities, provided there is full compliance with the rules and regulations of the institution and such standard technical procedures as may be formulated by the attending or active medical staff and adopted by the hospital.

The attending or active medical staff treats the charity cases which are assigned to the various services and also cares for those cases which come to the hospital as emergency or otherwise, without the choice of an attending physician. Moreover, it is held responsible for the promotion and development of the medico-administrative and scientific policies of the institution in cooperation with and subject to approval of the governing board. Sometimes the open hospital allows physicians in good standing, such as those on the courtesy medical staff, to treat certain charity patients who may be referred to them, provided they work under supervision of the attending medical staff.

Those who favor the open type of medical staff organization believe that it raises the general standard of medical practice in the community because it gives more physicians an opportunity to use the hospital facilities, and thus helps them keep abreast of the advances in scientific medicine. However, the development of efficient medical staff organization in an open hospital is beset with difficulties because a large number of physicians working therein have no direct interest in the hospital except as a facility for the care of their patients. Therefore, an efficient organization is most essential in the open hospital on account of variation in scientific or professional qualifications and clinical skill existing among the physicians privileged to use the hospital. Hospitals must rely largely on proper organization as an effective means of supervising and controlling the clinical work.

*Definition of "closed hospital"*

A "closed hospital" is one in which all professional services, private and charitable, are provided and controlled entirely by the attending or active medical staff. No other physicians are permitted to treat patients in the hospital except under consulting agreement with members of the medical staff and approval of the governing board.

An efficient medical staff organization can be developed more readily and the clinical work kept under better control in a closed hospital, inasmuch as the medical staff consists of a relatively small group of selected physicians who are directly responsible for the professional work on their respective services. Organization is just as essential in a closed as in an open institution in order to provide a strict accounting of the professional work at all times and to maintain the highest standards possible in medical service. Either the "open" or "closed" hospital can maintain an excellent standard and qualify for approval by the American College of Surgeons if it is well organized and the medical staff is competent and ethical.



*Functions of the medical staff*

The medical staff has two main functions to perform:

1. Medico-administrative: To act in an advisory capacity to the governing board of the hospital on professional problems.

2. Clinical: To render professional service to the patients in accordance with the precepts of modern scientific medicine, to maintain its own efficiency, to participate in education, and periodically to audit professional work.

In order to carry on these functions successfully, all physicians privileged to work in the hospital must be organized. This duty implies an organization of self-government which will provide for original selection and later promotion of individual members, both selection and promotion being based on merit. Thus there will be a coordination of effort in the care of the sick and such discipline as must prevail if a scientific and ethical organization is to be perpetuated. As an advisory group to the governing board, the medical staff may disclose certain defects in the organization of the hospital during the course of the periodic medical audit, and in the spirit of constructive criticism such discrepancies may be called to the attention of the administration. There is often, however, a tendency for the members of the medical staff personally to attempt to correct administrative errors, a tendency which should be avoided. It is a singular fact that the governing board of the hospital must, of necessity, share an important part of its responsibility with the physicians who are privileged to work in the institution, and this includes the actual care of patients which must be given by physicians legally qualified to practice in the State or province since the hospital cannot be licensed for this purpose. Also, scientific standards may be initiated and encouraged by the governing board, but ultimately they must be executed by the medical staff. The physician should face the results of his professional work frankly and know why he has been successful or unsuccessful. If he is conscientious and a member of the modern school, he will assure himself that all the facts and conclusions have been recorded, that the final note of the record is a true statement of the results obtained, and that the reason for success or failure is given.

Much of the education of physicians, nurses, and others must be supplied by the medical staff. Although not primarily responsible for the educational activities of the institution, the medical staff must be prepared to assist the governing board in this duty. While these educational activities are formulated by the governing board and its administration, the medical staff acts in an advisory capacity and is responsible for delivering lectures and conducting demonstrations whenever called upon. In the educational activities of the institution which are carried on for the welfare of the community, care must be exercised that there be no conflict with the activities of organized medicine as represented by the county and State medical societies. In these extramural activities of the hospital, the medical staff should not only participate, but as representatives of organized medicine, it should have equal authority in their selection and in determining the extent to which they will be promoted.

Finally, the medical audit can be conducted only by those trained in the art and science of medicine. Under these circumstances there must be a medical staff which functions as a collaborating, self-appraising organization responsible to the governing board for details of its work, for results produced, and for advice and assistance to the administration. Merely to state that good results have been produced is not sufficient. The well organized medical staff must go further and evaluate its work in terms of morbidity and mortality, proving that the incidence of successes at least equals general averages and that the failures were inevitable. This audit, together with the study of cases for educational purposes, demands that individuals and committees be willing to do the necessary work. Every member of the medical staff must be ready to give the time required for such committee work and to attend the meetings at which reports are presented.

Emphasis has been placed upon medical staff organization to the extent that it constitutes an entire section of the minimum standard for hospitals and is made a primary requisite for the successful application of the principles of hospital standardization as laid down by the American College of Surgeons.

The duties and responsibilities of the medical staff outlined in the following sections in no way imply that the staff should usurp the rights and powers of the governing board; instead, the physicians are expected to aid the administration in building up the institution by giving freely of their advice and services when problems of medical administration and scientific policies arise. The medical staff should assist the governing board in every way possible to promote the best care of the patient.

### *Medical staff groups*

The formation of medical staff groups or divisions is practicable in most hospitals. The first step necessary is differentiation of the medical staff. Although grouping may vary to some extent in different types of institutions, five basic divisions may be considered and adopted insofar as they are applicable and warranted by local conditions.

1. Honorary medical staff: Consists of physicians who are not active in the hospital and who are honored by emeritus positions. These may be:

(a) Physicians who are retired from active hospital service.

(b) Physicians of outstanding reputation.

The honorary medical staff is appointed by the governing board on recommendation of the active medical staff and has no assigned duties or responsibilities.

2. Consulting medical staff: Consists of recognized specialists who are active in the hospital or who have signified willingness to accept such appointment. Appointment is made by the governing board on recommendation of the medical staff. Credentials are not required, and the proposed member may be invited to accept appointment. The duties of the members of the consulting medical staff are to give their services without charge in the care of free patients when requested to do so by members of the active staff.

3. Active medical staff: Consists of those physicians who are selected to attend free patients and to whom all such patients should be assigned. Even when there are no indigent sick this is the group which is most actively interested in the hospital. Since its members must assist in maintenance of medical standards in the hospital, it is necessary that they be given authority commensurate with their responsibility. In internal medical staff government they should be the authoritative body; in questions of policy concerning which the governing board requires advice it is the active staff which should be consulted. Only members of the active medical staff should be eligible to vote or hold office. Appointments are made annually from former members of the active staff, and insofar as possible, vacancies are filled by promotion of members of the junior divisions who have signified a desire to become more active in the work of the hospital. Physicians not resident in the community are not eligible for membership on the active staff. Appointment is made by the governing board on recommendation of the active staff.

4. Associate medical staff: Consists of junior or less experienced members, or of physicians who have not been actively interested in the work of the hospital but have expressed a wish to become active as vacancies occur. They should be assigned to services in the same manner as that provided for the active staff and each should be associated as a junior with a member of the active medical staff. They should attend free patients assigned to their senior in accordance with assignment by the senior. Appointments to the active medical staff should, whenever possible, be by promotion from the associate medical staff. Members of the associate staff should be required to attend a majority of meetings of the medical staff under penalty of reverting to the courtesy medical staff. They should have all the privileges of medical staff membership except that they should not be eligible to vote or hold office. They may be appointed to act on all committees except the executive committee and the credentials committee.

5. Courtesy medical staff: Consists of those members of the medical profession eligible for staff membership, who wish to attend private patients in the hospital, but who do not desire to become members of the active medical staff or who, by reason of residence, are not eligible for such appointment. They should be appointed in the same manner as other members of the medical staff and should have all the privileges of such membership except that they should not be eligible to vote or hold office. While they should not be obligated to attend medical staff meetings, it is expected that they will do so whenever possible, and if a case treated by a member of the courtesy medical staff is to be presented at a meeting of the medical staff, he should be notified and required to attend under penalty of forfeiting his staff membership.



There are other divisions which may be considered, such as the senior medical staff, junior medical staff, adjunct medical staff, and clinical assistants. Since the divisions of the medical staff and the terminology vary so greatly, an arbitrary classification cannot be established. Emphasis is placed upon the assignment of every physician privileged to work in the hospital to a definite status in one of the divisions. No physician should be permitted to attend patients in the hospital until he has been properly appointed and assigned to one of the recognized divisions of the medical staff. Finally it is desirable that the medical staff organization provide for advancement of the younger men, and that it assure adequate control and supervision of all professional activities. The degree to which the principles of medical staff organization have been applied is a reliable index to the standards maintained and to the service which is rendered to the patient.

#### *Departmentalization of the medical staff*

Every hospital should give special consideration to the differentiation of the medical staff into the various specialties insofar as such classification is practicable. Division into departments fixes responsibility more definitely, stimulates scientific interest in the medical specialties, and promotes the proper administration of the professional services. Departmentalization of the medical staff does not mean that every general practitioner shall become a specialist, although opportunity must be given to physicians who desire to specialize after they have had the proper fundamental training. The extent to which a medical staff may be departmentalized is generally proportional to the degree of specialization of its members.

In the small hospital where there is often little or no specialization among the physicians, departmentalization of the medical staff to any extent is not possible. Under such conditions a general medical staff is more practicable with, however, the two major divisions—medicine and surgery.

In larger communities where the physician may restrict his practice more readily to a chosen field, specialization is usually sufficient to warrant the formation of more clinical divisions. At least, sections in medicine, surgery, obstetrics and gynecology, and ophthalmology, otolaryngology, and rhinology may be established. Each department should be under the direction of a supervisory head or chief who is responsible for the development and supervision of the service.

As the hospital increases in size and the medical staff becomes larger and more differentiated, all the main divisions can be established. In these institutions are departments of medicine, surgery, obstetrics and gynecology, pediatrics, urology, orthopedics, ophthalmology, otorhinolaryngology, dermatology, neurology, psychiatry, anesthesia, pathology, and radiology, each with its responsible head or chief in charge of the service.

Departmentalization is further extended in communities where the medical profession is highly specialized, and particularly in teaching hospitals. Additional departments are created by subdividing the main divisions, placing each under the direction of a chief in addition to the chief of staff who is at the head of the entire organization. Departmentalization in its highest form embraces the full range of clinical specialties as follows.

Medicine, which includes the following services:

Cardiology	Endocrinology
Communicable diseases	Gastrointestinal diseases
Dermatology and syphilology	Neuropsychiatry
Diseases of the lungs	Pediatrics
Diseases of metabolism	

Surgery, which includes the following services:

Malignant tumor surgery	Orthopedics
Neurological surgery	Plastic surgery
Obstetrics and gynecology	Proctology
Ophthalmology	Thoracic surgery
Otorhinolaryngology	Traumatic surgery
Oral surgery	Urology

Other departments of the medical staff related to the various specialties are:

Anesthesia	Radiology
Pathology	

In addition to the departments of the medical staff, the establishment of a department of dentistry may be indicated in some hospitals inasmuch as in recent years the advances in the field of dentistry make hospitalization preferable for the proper treatment of certain types of dental patients. Dentists desiring hospital



privileges should qualify as to ethics and competency in their specialty and, on appointment, be assigned to the dental staff which may constitute a special section of the general staff of the hospital.

In order to promote scientific work in the hospital, departmentalization of the medical staff, so far as practicable and possible, is essential. Too often the weakness in medical staff organization is due to lack of well organized clinical divisions and to failure of the head or chief of the service to assume his full responsibility in exercising control of the work in the department which is assigned to him.

#### *Officers and committees*

In order to fulfill the functions of the medical staff the following officers and committees are required: President, secretary, and possibly an executive committee, which will suffice for a limited medical staff membership in the small hospital.

In larger institutions where a more extensive organization is indicated there are a president or chief, a vice president or vice chief, a secretary-treasurer, and six standing committees as follows:

1. Executive committee or medical board consisting of heads of the various clinical divisions to coordinate the activities and policies of the various departments.

2. Qualifications or credentials committee, to review the qualifications of physicians applying for membership on the medical staff, and charged with the responsibility of regulating the requirements for admission to practice in the hospital, and of making recommendations on medical staff appointments, promotions, and privileges to do major surgery.

3. Medical records committee, to supervise and appraise the medical records in order to see that they are kept up to the required standard.

4. Program committee, to prepare programs for medical staff conferences.

5. Joint conference committee, to function as a correlating unit between the medical staff and the governing board.

Standing committees should function actively at all times and present reports of progress at medical staff conferences. Special committees may be appointed for consideration of problems that arise from time to time. It is vitally important that the chairman of each committee be especially qualified for leadership and that the membership be active inasmuch as the purpose of the committees is to expedite work that the medical staff as a whole would find difficult to accomplish. The medical staff rules and regulations should state definitely the duties of each committee. As the membership of these groups frequently changes from year to year, a complete statement of authorized duties and responsibilities should be incorporated in the staff rules, and this will do much toward keeping committees active.

#### *Relationship of medical staff to governing board*

The governing board is the supreme authority in the hospital, responsible for the management, control, and functioning of the institution. The medical staff is responsible to the governing board for the clinical and scientific work of the hospital and may be called upon to advise regarding professional problems and policies. Although there is a liaison officer between the two groups, in the person of the superintendent or administrator, getting together and presenting viewpoints is particularly advantageous in the successful administration of a hospital. For the adequate care of the patient, a common ground of thought and of action must be established. This necessitates sympathetic cooperation between the medical staff and the governing board so that the board can better understand medical problems and the medical staff can better understand administrative problems.

To establish this cooperation and the desired official relationship with the hospital administration should there be medical representation on the governing board? If so, how should it be effected? Several methods have been advanced, each having its own advocates. The American College of Surgeons approaches the problem with an open mind, believing that each case requires special consideration. However, national organizations and individual authorities of outstanding repute in hospital administration, basing their opinion on years of observation and experience, advise against the policy of having a representative of the medical staff as a member of the governing board of the hospital. The following constitute 10 of the major objections:

1. Membership on the governing board gives undue publicity to the individual physician, thereby placing him in a position which he may not have

earned by his professional efficiency, and favorably affecting his private practice.

2. Members of the governing board who are physicians may readily use their administrative position to promote themselves on the medical staff of the hospital.

3. Physicians appointed to the governing board are oftentimes not elected by the medical staff and therefore are not regarded by the other physicians as their chosen representatives.

4. Placing a physician on the governing board not only tends to create jealousy among his confreres on the medical staff, but blights the interest of other staff members when they have no connection with the governing board.

5. The physician-member of the governing board may be regarded by the medical staff as an inspector who is unduly critical of their work, thus creating a barrier which prevents cooperation between the governing board and the medical staff.

6. When the legal responsibility imposed upon a hospital trustee is considered, it is realized that a physician who is also a trustee under certain circumstances might be obliged to assume a double liability.

7. There is a tendency occasionally on the part of the medical representative to express his own personal judgment rather than the collective or group opinion of the medical staff which he represents.

8. The hospital may encounter difficulty in adopting the commendable practice of making medical staff appointments annually if preferred physicians are retained on the governing board.

9. A physician on the governing board may exert his authority in the employment of hospital personnel, which eventually may lead to charges of favoritism, thereby disturbing the morale of the institution.

10. Leading hospital authorities and recognized national organizations believe that it is an undesirable practice to have a member of the medical staff on the governing board of a hospital.

Since prevailing opinion is opposed to the practice of appointing a member of the medical staff to the governing board of a hospital, by what other means can the necessary cooperation be obtained?

Some institutions, considering it desirable to have the medical point of view represented on the governing board, appoint a retired physician as a member. There can be no serious objection to this, provided the physician selected is one who keeps abreast of medical progress, appreciates the needs of the modern hospital, and refrains from interfering with the administration. Other institutions prefer a representative committee, elected by the medical staff, to meet with the governing board. Still other institutions favor a medical council, comprising generally the chief of the medical staff, heads of departments, or senior members of the staff, and the superintendent as a member *ex officio*. This group confers with the management on medico-administrative problems and represents the medical staff as an executive committee.

A fourth plan, generally conceded to be the most satisfactory of all, calls for a joint conference committee. This committee consists of representatives of the medical staff and the governing board, and meets regularly to discuss medico-administrative subjects of mutual interest. Such conferences place the medical staff, through its selected representatives, in an advisory capacity, and provide an effective means of assisting in the administration of the hospital and the development of sound professional policies.

Obviously, no one method can be applied satisfactorily to all institutions. Each hospital must make its own decision in this respect, adopting an arrangement most suitable to its own needs. (For complete details of bylaws, rules, and regulations for medical staffs see addendum I, pp. 78 to 97.)

#### CLAUSE II OF THE MINIMUM STANDARD FOR HOSPITALS

That membership upon the medical staff be restricted to physicians and surgeons who are (a) graduates of medicine of approved medical schools, with the degree of doctor of medicine, in good standing, and legally licensed to practice in their respective States or Provinces; (b) competent in their respective fields; and (c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatsoever, be prohibited.



*Responsibility of governing board in selecting a medical staff*

Selection of the medical staff constitutes one of the most serious responsibilities of the governing board of the hospital. By virtue of the authority vested in it by law or charter, the governing board is charged with the duty of selecting its agents, including the medical staff. This authority cannot be shared with or delegated to any other individual or group. Such an interpretation of the law is based on the principle of respondent superior, by which the master, or one who expects to profit by the action of his agents, is responsible for their negligence. In the past it was believed that eleemosynary hospitals were exempt from this ruling inasmuch as no financial profit was expected or desired, but decisions of courts have reversed this opinion in many instances and have placed direct responsibility for selection of the medical staff upon the governing board in all hospitals.

Further, supreme courts have ruled that whenever a hospital fails to exercise due and reasonable care in the selection of its agents it is liable. In order that the governing board may use due and reasonable care in the selection of the medical staff, it must retain and exercise its prerogative to appoint such members. Several court decisions have specifically stated that when the governing board failed to appoint the medical staff, it was negligent in its duties.

Only by its right to exclude licensed practitioners who are considered unqualified professionally can the governing board be held responsible for the care of patients; to be compelled to grant hospital privileges to all licensed physicians constitutes an invasion of property rights. Such a policy constitutes a menace to health and lowers professional standards to the point of undermining public confidence.

Physicians and nonmedical practitioners licensed under other standards of qualifications who have brought suit to compel hospitals to grant them admission have claimed that they have a legal right to practice and that this right applies to all public hospitals in their community. The reply is that the governing board of a hospital, regardless of ownership, has the right to say who shall or shall not work therein. The community hospital has as much right to select its medical staff as has the Government-supported university to select its faculty.

While it is true that in some States the laws specifically provide that any licensed local physician must be admitted to practice in the hospital, and while these same States frequently license graduates of inferior medical schools and persons who have not been educated in the basic sciences, it is obvious that if hospitals are forced to obey such laws, they seriously jeopardize the lives and health of their patients. In some cases the governing board has tried to solve the problem by admitting all licensed practitioners and attempting to control them by internal rules and regulations. In other cases an attempt has been made to bar the practitioners who are regarded as unqualified. In more than one instance supreme courts have upheld the latter action, and it seems probable that more courts will support the right and duty of governing boards to exclude unqualified practitioners from hospital privileges.

The principles of hospital standardization not only emphasize the responsibility of the governing board in selecting the medical staff, but they offer a clear-cut outline of qualifications for appointment which is recognized universally as a guide. Clause II, Minimum Standard for Hospitals, states:

"That membership upon the medical staff be restricted to physicians and surgeons who are (a) graduates of medicine of approved medical schools, with the degree of doctor of medicine, in good standing, and legally licensed to practice in their respective States or Provinces; (b) competent in their respective fields; and (c) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatsoever, be prohibited."

*Qualifications for membership on the medical staff*

Qualifications for membership on the medical staff should be based on ethics, education, experience, character, loyalty, and a signed agreement to abide by the constitution and bylaws of the hospital.

1. Ethics: In considering the eligibility of a physician for hospital privileges the codes of ethics of the American College of Surgeons, American Medical Association, and Canadian Medical Association must be regarded as a major requisite. A physician who is not ethical is not desirable.

2. Education: The following minimal educational requirements are deemed essential for practitioners of medicine:



(a) Secondary school education equivalent to a 4-year course in an accredited high school.

(b) Premedical course, consisting of at least 2 years in a recognized college.

(c) Medical course of 4 years completed successfully in an approved medical school.

(d) Practical experience of at least 1 year as an intern and 1 or more years as a resident in an approved hospital.

3. Experience: Competence and experience are relative terms which should be interpreted in their broadest sense. The conscientious physician who has fulfilled the educational requirements shall not be excluded on account of inexperience, provided he has the judgment to realize his limitations and call for a consultation and assistance when necessary in the best interests of the patient.

4. Character: Careful selection of members of the medical staff on the basis of character as well as educational qualifications is effective in preventing unethical practices.

5. Loyalty: A physician who accepts a place on the medical staff should have sufficient pride in the hospital to put forth every effort toward the development of efficient professional service and should support the management in the proper administration of the institution. Furthermore, loyalty implies good will and patronage and the hospital may rightfully expect its medical staff members to utilize its available facilities.

#### *Method of appointment to the medical staff*

Every hospital should adopt a definite plan of making appointments to its medical staff and should incorporate this in the bylaws, rules, and regulations. A uniform procedure of application and appointment suitable for all candidates for membership on the medical staff, such as the following, is recommended:

1. Application: The physician seeking hospital privileges submits a written application, according to a prescribed form (addendum V, pp. 104-105), to the superintendent, secretary, or other authorized official of the hospital. The application sets forth at least the following information pertaining to the applicant:

(a) Identification data.

(b) Medical college from which applicant was graduated and year of graduation.

(c) Internship, residency, postgraduate work, and subsequent experience.

(d) Name of medical society or societies of which applicant is a member in good standing.

(e) List of scientific papers or essays which applicant has written and where published.

(f) National scientific meetings applicant has attended during the previous 3 years.

(g) Names of three acceptable references from the community in which the applicant is practicing or formerly practiced.

(h) Signature of applicant to agreement to abide by the bylaws, rules, regulations, and standard policies of the institution, these to include resolution against division of fees in accordance with the requirements of hospital standardization if granted the privilege to work therein. (When the application is signed and the physician is extended the privileges of the hospital, a contract exists between the applicant and the hospital which will insure better cooperation on the part of the former in conforming to the policies of the institution.)

2. Credentials: The medical staff or a committee of the medical staff, or the chief of staff, or head of the department considers the application together with all credentials and other available information, and submits recommendations to the governing board which makes final disposition of the case, either as being accepted, deferred for additional information or further observation, or rejected. It is desirable to have a properly constituted credentials committee for this purpose. The personnel of such a committee must be carefully selected, the members being fair, frank, and conscientious, and at all times free from the influence of politics or prejudices. The findings of this committee are transmitted in writing to the governing board, which has the privilege of calling for more information if deemed

necessary. All findings should be carefully recorded and duly signed by the proper officers.

3. Appointment: Appointment carries with it full or restricted privileges to work in the hospital, and the applicant becomes a member of the medical staff. The notice of appointment is given officially and should be a matter of record in the hospital. It is advisable to extend hospital privileges for 1 year only, with the understanding that if the candidate's work and conduct have been satisfactory, further extension of privileges may be granted. This method saves the hospital embarrassment when mistakes occur in granting privileges to unworthy physicians.

4. Record of professional efficiency and conduct: The hospital keeps a careful, confidential record of the professional efficiency and conduct of each physician privileged to work therein. This is absolutely necessary so that the governing board may make the most intelligent appraisal of the ability and fitness of the physician for promotion on the medical staff or appointment to positions of trust and responsibility. Appointments of this nature should be made only after careful consideration of the applicant as to ethics, competency, loyalty, and other qualities which might favorably or adversely influence subsequent relations with the hospital.

### *Fee-splitting*

Fee-splitting is a transaction for financial gain practiced under contract, understanding, or by consent—silent or spoken—through which a portion of the compensating fee that a specialist or practitioner receives from a patient (presumably for his own services) is paid directly or indirectly to another individual or agent who was influential or instrumental in bringing the patient to the specialist or practitioner for operation or treatment. In other words, the term "fee-splitting," reduced to its simplest interpretation, means the buying and selling of patients on a commission basis. Financial gain supersedes medical science and the best interests of the patient. Also the moral obliquity of both parties to this transaction naturally biases any medical or surgical judgment that either of them may possess. Ingenious subterfuges not easily recognized are resorted to by those who are most successful in this practice because they desire to avoid the penalty of adverse public opinion or professional ostracism. The fee-splitter generally uses every means necessary to secure connection with a recognized hospital and acquire membership in local medical societies in order to facilitate his nefarious practice while sheltered by a reputable institution and enjoying association with ethical physicians.

While fee-splitting may not be an issue in all communities and in all hospitals, it has been necessary to establish a uniform regulation to avoid discrimination and to require the medical staff and governing board of every hospital desiring approval to go on record against this practice. Once on record, it is the duty of the hospital management to exercise continuous vigilance to prevent fee-splitting under any guise. The institution which harbors fee-splitting must share the guilt with the perpetrator of the crime, and the onus of guilt, when question arises, is also shared by the hospital.

Governing boards must ever realize their responsibility in operating honest hospitals. They must have the courage to take action against unethical practices, not only for the sake of the patient and the reputation of the hospital, but also in support of the honest physicians who are the bulwark of all that is good in medical practice. Institutions which extend rights and privileges equally to unscrupulous practitioners are unfair to the trustworthy physicians on the medical staff.

From the standpoint of medical and nursing education, a fee-splitting atmosphere in a hospital is detrimental to the proper cultural development of the intern, the medical student, and the student nurse inasmuch as they are in the formative years of their professional lives. While technical training is vitally important, it can count for nothing without a good background of ethics and respect for scientific medicine. Professional ethics and ideals of vocation cannot be implanted and developed in an environment which condones fee-splitting.

### *Principles of Financial Relations in the Professional Care of the Patient*

1. Each doctor who participates in the care of a patient is entitled to compensation from the patient commensurate with the services rendered.

2. Whenever practicable and possible the attending doctor should acquaint his patient with his financial responsibility to those concerned with his care.



3. Each doctor concerned in the care of the patient should give or send directly to the patient a detailed statement showing charges for professional services rendered.

4. Combined statements should be avoided as they may constitute subterfuges for fee-splitting.

5. Each doctor who participates in the care of the patient should send a personal receipt directly to the patient for all moneys received from the patient or other legitimate or authorized source.

6. Insofar as possible, a third person should not enter into the financial relations between doctor and patient, and to this end hospitals should be discouraged from determining or collecting fees for doctors.

7. An exception to the foregoing principles must, of necessity, be made when there is a formally organized clinic or legal partnership which in effect may be regarded as an individual and which acts in that capacity. This principle should apply also when the clinic and hospital are combined and under the same ownership.

8. The practice of having the referring doctor act as assistant or anesthetist at an operation should be discouraged, unless he is competent for either or both of these duties by virtue of his training and continuous experience.

9. A surgeon who has a regular assistant at operations may pay him directly. When the assistant has referred the patient to the operating surgeon, he should follow the procedure outlined in paragraph 3.

The evils of fee-splitting are well known to the medical profession and to hospitals. They must realize that the best interests of the patient can be properly protected only when service rendered is ethical as well as efficient. In this respect the service must be entirely free from any element of commercialism. With the practice of fee-splitting this is impossible, for too frequently the monetary aspect is more influential than the guiding forces of scientific medicine.

While in some States there have been attempts at legislation to combat the practice of fee-splitting, it is believed that the most effective method of abolishing it is through the intelligent cooperation of the medical profession, the hospitals, and the public, and especially, education of the public as to its evils.

The board of regents of the American College of Surgeons has adopted definite principles of financial relations in the professional care of the patient. These are stated on the preceding page.

The American College of Surgeons unreservedly condemns the practice of fee-splitting under any guise whatsoever, and a hospital in which this pernicious practice is known to exist cannot secure or retain a place on the approved list. Each hospital is requested to take a firm stand by the adoption of a resolution against fee-splitting and by endorsement of the above principles by the medical staff and governing board. Endorsement consists of individual signatures to a resolution of all physicians who have hospital privileges. When completed, a copy of this document must be filed with the American College of Surgeons.

Besides a clause in the bylaws of the medical staff forbidding unethical conduct, the resolution referred to above is a specific declaration against the division of fees in any form and includes an agreement to render separate statements and issue separate receipts. It is not acceptable to substitute explanation in this requirement stating that the medical staff shall abide by the code of ethics of a stated organization or society: each hospital must have its own specific pledge against the division of fees. An acceptable resolution follows:

I hereby declare that I shall not engage in the practice of division of fees under any guise whatsoever. In complying with this principle I understand that I am not to collect fees for others referring patients to me, nor permit others to collect fees for me, nor to make joint fees with physicians or surgeons referring patients to me for operation or consultation, nor permit any agent or associate of mine to do so.

Further, I agree to comply with the principle that all physicians and surgeons participating in the care of a patient shall render separate statements and issue separate receipts.

Signed \_\_\_\_\_

Dated \_\_\_\_\_

Every fellow of the American College of Surgeons agrees to abide by the by laws of the college and by such rules and regulations as may be enacted from time to time, and subscribe to the following fellowship pledge and declaration:



*Fellowship Pledge*

Recognizing that the American College of Surgeons seeks to develop, exemplify, and enforce the highest traditions of our calling, I hereby pledge myself, as a condition of fellowship in the college, to live in strict accordance with all its principles, declarations, and regulations. I particular, I pledge myself to pursue the practice of surgery with thorough self-restraint and to place the welfare of my patients above all else; to advance constantly in knowledge by the study of surgical literature, the instruction of eminent teachers, interchange of opinion among associates, and attendance on the important societies and clinics; to regard scrupulously the interests of my professional brothers and seek their counsel when in doubt of my own judgment; to render willing help to my colleagues and to give freely my services to the needy. Moreover, I pledge myself, so far as I am able, to avoid the sins of selfishness; to shun unwarranted publicity, dishonest money-seeking, and commercialism as disgraceful to our profession; to refuse utterly all money trades with consultants, practitioners, or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation. Finally, I pledge myself to cooperate in advancing and extending, by every lawful means within my power, the influence of the American College of Surgeons.

*Declaration*

Upon my honor as a gentleman, I hereby declare that I will not practice the division of fees, either directly or indirectly, in any manner whatsoever.

## CLAUSE III OF THE MINIMUM STANDARD FOR HOSPITALS

That the medical staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide: (a) that medical staff meetings be held at least once each month; (b) that the medical staff review and analyze at regular intervals their clinical experience in the various departments of the hospital, such as medicine, surgery, obstetrics, and the other specialties; the medical records of patients, free and pay, to be the basis for such review and analysis.

*Bylaws, rules, and regulations*

The first step in the organization of a medical staff is to formulate complete bylaws, rules, and regulations which set forth the organization, duties, responsibilities, and procedures, which are to be approved by the medical staff, signed by the chairman and secretary, and submitted to the governing board of the hospital for adoption. (See addendum I, pp. 78-97.)

Since the governing board is responsible for the conduct of the hospital, the bylaws, rules, and regulations should be officially adopted and attested by the signatures of its chairman and secretary in order to make the document effective. Finally, the signatures of all members of the medical staff should be affixed as evidence of good faith and agreement to abide thereby. In order to prevent the bylaws from becoming antiquated and disregarded, they should be revised every 3 to 5 years by a committee of the medical staff and the superintendent, approved by the governing board, and a copy placed in the minute book of the medical staff proceedings for reference. Each hospital is expected to use its initiative in evolving regulations which are applicable to its own needs, and in addition, to adopt certain major principles which are fundamental and are to be embodied in all medical staff bylaws, rules, and regulations, such as the following:

1. A statement of the necessary qualifications which a physician must have to be privileged to work in the hospital. This may vary in detail in different hospitals, but in every instance the basic qualifications as set down in clause II of the minimum standard for hospitals must be observed. It is exceedingly essential that every hospital maintain a definite standard of qualifications required for medical staff membership.

2. An outline of procedure in extending privileges to physicians to work in the hospital. Granting of privileges is of vital importance and must be carefully guarded at all times. A definite procedure including application, credentials, and appointment must be followed.

3. A descriptive outline of medical staff organization. This shows the various staff divisions, clinical departments or service, and the officers and committees of the medical staff, and defines so far as possible duties, relations, and responsibilities of each. Routine procedures should be outlined by the medical staff whenever possible so as to expedite the work of the hospital.

4. A definite and specific statement forbidding the practice of the division of fees under any guise whatsoever. It is not acceptable to substitute explanation in this connection, stating that the medical staff shall abide by the code of ethics of such and such organization or medical society. Each hospital must have its own specific resolution or pledge against fee-splitting acceptable to the American College of Surgeons. (See p. 20.)

5. Provision for keeping accurate and complete clinical records. Clinical records should be written for all patients treated in the hospital and should be completed at the time of discharge. Regardless of who writes the record or how it is obtained, the attending physician, by virtue of using the facilities provided him by the hospital, is responsible ultimately for furnishing complete, accurate, and scientific records.

6. Provision for regular meetings of the medical staff at least once a month. It is essential that the medical staff meet regularly as a whole or in groups or departments for the thorough review and analysis of the clinical work.

7. A statement to the effect that the physician in charge of the patient shall be responsible for seeing that all tissue removed at operation is delivered to the hospital pathologist, and that a routine examination is made of such tissue. It is vitally important that tissues which are removed at operation be examined pathologically and reported upon.

8. Provision for routine examination of all patients on admission and recording of preoperative diagnosis prior to operation. Except in emergencies no patient should be subjected to an operation before completion of the clinical record which should include the preoperative diagnosis.

9. A ruling permitting a surgical operation only on consent of the patient or his legal representative, except in emergencies. This precaution is advisable in case of legal involvements or misunderstandings with patients, guardians, or others.

10. A regulation insisting that physicians' orders be in writing. In this connection, it is advisable that only recognized abbreviations be used, as harm to patients has been known to result from misinterpretation of dosage symbols.

11. A statement giving sole authority to the hospital superintendent in the admission of patients. Recommendations for admission may be made by the physician but the final decision should rest with the superintendent.

12. A statement providing that major operative obstetrics or curettages shall not be performed except after consultation with at least one member of the regular staff. The consultant should write his finding and recommendations, and this report should form a part of the patient's record.

(Sample sets of bylaws, rules, and regulations governing the medical staff will be found in addendum I, pp. 78 to 97.)

### *Medical staff conference*

A fundamental requirement of the hospital standardization program of the American College of Surgeons is that in each hospital a medical staff conference shall be held at least 12 times a year, that is, once each month, and if possible more frequently, to review and analyze the clinical experience in the various departments, and that the medical records of patients shall be the basis for such review and analysis. Prior to inauguration of the hospital standardization movement the practice of the medical staff conducting a periodic medical audit was the exception rather than the rule. Each physician was inclined to carry on his work in his own individual manner without regard for results accomplished by his associates. Absence of proper staff organization caused a lack of coordination among physicians and failure to review the medical records of patients in the hospital. Too often there was no plan in force to determine whether or not death or failure to respond to treatment was due to negligence and whether or not every available means of treatment had been employed. As the care of the patient was frequently considered the sole responsibility of the physician in charge, there was little incentive for consultation and the exchange of scientific knowledge so essential to the proper care of patients. To remedy these deficiencies, the American College of Surgeons insisted in its hospital standardization program that medical staff conferences be held regularly at least



once each month. Today, as a result, in the modern, properly organized hospital, the medical staff functions as a unit. Individual interest and responsibility have been replaced by group interest and effort. Without coordination in the medical staff it is impossible to achieve the results desired from the medical staff conference.

Medical staff conferences must be held at least once each month in order to accomplish a thorough review of the clinical work. In the majority of hospitals, meeting of the entire medical staff as a single unit is practicable, but in the large, departmentalized institution the various clinical departments find it necessary to meet in sections and to convene weekly in addition to the general monthly medical staff meeting if all phases of the clinical work in each department are to be carefully analyzed.

Occasionally the question arises as to combined medical staff conferences of two or more hospitals which are located in the same community. The American College of Surgeons does not approve of joint medical staff conferences because:

1. There is insufficient time for a thorough review and analysis of the clinical work in two or more hospitals when the staff meetings are combined.
2. There is inhibition of frank discussion when the work of one hospital is reviewed in the presence of its neighbor, especially if any rivalry or competition exists between the institutions.
3. There is a tendency to prevent the development of a unified, well coordinated medical staff and to diminish the interest of individual members of the medical staff in any particular hospital.
4. Joint medical staff conferences are not productive of building up a distinctive professional atmosphere around the individual institution—a handicap to every hospital which must depend for its success upon a high professional status created by its medical staff.
5. Joint medical staff conferences invariably become social and medical meetings where scientific papers are presented without regard to an analysis of the hospital service. In fact, in every known instance where joint medical staff conferences have been attempted, the real objective of the conference—the thorough review and analysis of the clinical work—was entirely missed.

#### *Purposes of medical staff conference*

The regular medical staff conference is designed to fulfill the following purposes:

1. To keep the scientific work of the hospital up to the highest standard which is attainable by means of a careful appraisal of the clinical work at regular intervals by the medical staff.
2. To provide means through which members of the medical staff can improve their medical knowledge. The medical staff conference affords opportunity for the physician to add to, readjust, and replace his fund of knowledge by exchange of opinions, by group consultation on problem cases in the hospital, and by discussion of procedures in modern hospital practice. Every physician, regardless of his medical education, experience, and postgraduate study, must continue to supplant and supplement his medical knowledge. No better facility exists for this purpose than the properly conducted staff conference in the approved hospital.
3. To encourage special studies and clinical research. An approved hospital with its organization, trained personnel, laboratories, clinical departments, and assembled data affords unusual opportunity for special study and investigation along practical lines. Therefore, a properly conducted medical staff conference can be an invaluable agent in promoting clinical research and the applied science of medicine.
4. To furnish opportunity to disclose any gross incompetency, commercialized work, and unnecessary or unethical practices which may exist. Since individuals who indulge in such practices cannot submit to investigation, the medical staff conference becomes an effective means of eliminating undesirable conditions from the hospital.

#### *Preparation of program for medical staff conference*

The preparation of a carefully arranged program should be started immediately after adjournment of the previous meeting. This requires an active program committee of three to five members, depending on the size of the hospital. In the smaller hospital it is advantageous for the administrator to be a member of the program committee. In the larger hospital, where the clinical departments



are highly organized, the heads of divisions, aided by interns and residents, are in a position to select cases for presentation.

When specialization has advanced to a high degree, the various clinical groups may elect to hold their own departmental conference separately. But the various specialties are closely interrelated and the specialist needs the concepts of other fields of medicine, just as the general practitioner benefits by having some specialized knowledge. Therefore, in addition to the departmental conferences, it is necessary for the entire medical staff to hold a general conference monthly to present and discuss cases from each department.

In order that the members of the medical staff may be familiar with the program and prepared to participate in the discussions, a copy should be sent to all members in advance of the meeting, and the monthly analysis report posted on the bulletin board in the staff room at a reasonable time before the meeting.

A proper program for the regular medical staff conference is here outlined:

1. Presentation of a report of professional work for the previous month by distributing copies of the monthly analysis report (addendum VI, pp. 106-107) to each member of the medical staff or placing the report on a blackboard. The chairman may call attention to salient points in the report rather than read it verbatim.

2. Presentation of committee reports by any standing or special committees which have functioned during the month. The medical records committee especially should have at hand a report prepared by the medical records librarian summarizing the work of the records department, the status of incomplete charts, and the deficiencies noted. The committee may comment further on the quality of the medical records and the principal defects, and initiate a plan for their improvement.

3. The clinical program:

- (a) Review of patients in the hospital with special reference to those presenting intricate diagnoses, questions of treatment, delayed recovery, and conditions inimical to the physical welfare of the patient.

- (b) Review of selected cases discharged since the last clinical conference with special consideration of selected deaths, unimproved cases, infections, complications, errors in diagnoses, and results of treatment.

- (c) Report of group studies of cases treated in the various departments with special reference to findings, treatment, and end results.

- (d) Presentation of selected cases of special interest affording valuable information in diagnosis or therapy.

- (e) Analysis of clinical reports from the various departments with comparative studies showing indications for improvement in treatment and further utilization and development.

- (f) Discussion of ways and means of improving the professional services in the hospital.

The first two topics outlined above, under section 3, should be included in the program of every staff meeting as they are essential requirements of hospital standardization. The remaining topics are optional and may be presented when time permits in order to diversify the programs and assure a more complete analysis of the professional services. The program of the regular medical staff conference should be devoted strictly to review and analysis of the clinical work within the hospital. A program consisting of an address by a visiting physician or the presentation of medical papers similar to those prepared for a meeting of the medical society is not acceptable for a medical staff conference. Such a program not only infringes upon that of the local medical society but misses the real purpose of the staff conference. Discussion of medico-administrative matters and professional policies is seldom the concern of the entire medical staff; these subjects can be handled more effectively by the regular or active staff either in special meeting or immediately preceding the clinical conference. In most hospitals the executive committee is the medico-administrative body which reports to the regular medical staff.

#### *Analysis of clinical work*

The systematic, periodic review and analysis of the clinical work is a vitally important function of every hospital interested in rendering the best possible care to its patients. The medical staff conference affords the best means of evaluating the professional work of the institution in terms of lives saved, chronic invalidism prevented, pain and suffering alleviated, and other results less tangible but equally beneficial to humanity. It is through analysis of performance that knowledge is gained for the benefit of future patients, for advancement of the

physician's knowledge, and for promotion of scientific medicine. There should, therefore, be the frankest possible discussion of all the clinical work, irrespective of its quality, in order that all members of the medical staff may constantly augment their armamentarium of knowledge.

In analyzing the clinical work in order to make an accurate appraisal of the professional efficiency of the hospital, the monthly analysis report, as found in addendum VI, pages 106-107, is used. This analysis should embrace:

1. Gross results: Gross results are usually expressed as: "well" or "recovered," "improved," "not treated," "in for diagnosis," and "died." Inasmuch as end results are not available, this analysis must be considered incomplete. It includes only consideration of immediate results and should be supplemented or replaced, if possible, by a later analysis showing actual end results. Meanwhile, the consideration of immediate results is better than lack of any estimate of results.

There is confusion between the second and third classes, "recovered" and "improved," a difficulty which would be eliminated were it always kept clearly in mind that it is the immediate result which is being considered. The question should be asked: "Has the patient recovered from the condition for which he sought treatment?" The patient who came to the hospital with appendicitis, had his appendix removed, and was discharged with an entirely healed and healthy wound, was recovered, although perhaps he was not well enough to go to work. The unimproved case is easier to define. The patient who leaves the hospital no better or perhaps worse than when admitted is in this category and the result may or may not be justified. In the categories "not treated" and "in for diagnosis" are those who refused treatment, those for whom it was found that treatment would be useless, and the steadily increasing number admitted for examination and diagnosis, treatment, if indicated, being carried on elsewhere.

2. Mortality rate: In analyzing the clinical work the study of mortality is usually considered of prime importance inasmuch as it is an index of the scientific efficiency of the hospital. All deaths need not be reviewed, but those which, under ordinary circumstances, should not have happened must be considered, for instance; deaths following appendectomy, herniotomy, or other conditions in which good results are usually obtained. There is no advantage in devoting time to inevitable deaths such as chronic tuberculosis, advanced carcinoma, and senility, unless there is a desire to review some particular group of diseases from the standpoint of clinical research. A very careful inventory of deaths occurring in the hospital during the period under review should be presented, however, with full discussion of cases selected as indicated. Occasionally, the gross or total death rate may be very high, yet the work of good quality, since the hospital may be receiving a great many patients in extremis or admitting those who are in an incurable stage of some disease. It is the net death rate which must be considered when statistics are compiled.

There are two methods of arriving at the net death rate of the hospital. The first is to study the individual death to determine whether any known means of treatment could have prevented it, that is, whether or not it was inevitable. This method is not generally used because of difficulty in arriving at uniform standards for comparison of statistics.

The second and generally accepted method is to classify arbitrarily all deaths occurring over 48 hours after admission as hospital or net deaths. This makes a mere uniform means of securing statistics of comparable value. It is true that many deaths occurring later than 48 hours after admission are inevitable, and it is equally true that many occurring in less than 48 hours are at least worthy of discussion, but an extended study of deaths in hospitals has shown that the error in one class offsets the error in the other, and that the use of the 48-hour dividing line gives as accurate a figure as can reasonably be expected.

3. Autopsy rate. The incidence of autopsies is rightly considered as a just and true measure of the scientific attitude of the members of the medical staff. Hospitals should make a continuous effort to increase the percentage of autopsies. To this end much has been said and written regarding means of securing autopsies, but in the last analysis success or failure rests to a great extent with the attending physician. If he is truly interested in scientific medicine, he will take the trouble to interview the relatives of the deceased and in most instances will secure permission for the autopsy. If he is



not interested and will not take the trouble, the autopsy rate may be low because no person in the organization can successfully replace the attending physician in securing the necessary permission.

4. Infections: Infections should be traced to their source, not limited to those occurring in the surgical service, which are more commonly reported because they are apparent. It must be remembered that the purpose of studying infections is prevention, that the case of scarlet fever developing two weeks after admission is usually as much a hospital infection as is the case of infected hernia wound, and that prevention is equally possible. All infections should be carefully recorded so as to come under review.

5. Consultations: Many hospitals find that at least 15 to 20 percent of patients treated would benefit from careful consultation. Moreover, the percentage of consultations is usually considered to be an index of co-operation and team work among the members of the medical staff. In determining the number of consultations only those which have been recorded are considered, although they may by no means represent the total number held. While informal or verbal consultations are undoubtedly valuable, as a rule these result in snap judgments founded on a more or less superficial examination of the patient and consideration of available data. The consultation which is properly recorded is certain to be an expression of opinion and recommendations based on careful study of the patient; thus it is of greater value.

6. Resulting audit: It should be noted that in the medical audit, as in the business audit, discussion is confined to individual items or individual cases. From deaths, infections, and other complications, debit items are selected. Credit items are the recovered and improved. In the last analysis there must be shown a balanced physical accounting, a physical surplus or deficit, depending upon results of the scientific work. As the business manager accounts for and justifies financial expenditures, so must the medical manager—the physician—account for and justify human life expenditures as expressed in deaths, complications, or poor results of any kind. An explanation of each is necessary, and from such an analysis and study all members of the medical staff will be more efficiently prepared to care for subsequent patients. The balance sheet on comparison with similar balances of other hospitals working under comparable conditions should show that the results produced are at least as good as can be reasonably expected. (See addendum II, pp. 98-101.)

### *Conduct of medical staff conference*

The success and the value of the medical staff conference depends to a large extent on the manner in which it is conducted. In this some of the more important aspects to be observed are—

1. Presiding officer: The chairman of the medical staff conference should be an experienced presiding officer, with initiative and personality conducive to arousing interest and enthusiasm. He must be able to conduct the meeting in a businesslike manner and direct the discussions along indicated lines. Every medical staff conference requires careful and energetic direction.

2. Preparation: It is essential that the program be prepared previous to the meeting in order that each physician who presents a case may have the subject matter well in hand and thus avoid a tedious presentation. As already stated, the medical staff conference program should be commenced immediately following the previous meeting.

3. Facilities: Proper facilities for the comfort of the members of the medical staff should be provided, so that they may enjoy the program to the fullest extent. These should include a comfortable room with ample furniture or equipment, as tables for the chairman, secretary, and records, librarian, readily visible blackboard, X-ray viewing box lantern, screen, and projection equipment for gross and microscopical pathological specimens. The room should be bright, cheery, and readily ventilated.

4. Time of meeting: The day and hour most convenient to the majority of the medical staff should be selected. It should not be held earlier than the middle of the month in order to permit the necessary time to prepare the program, close the medical records for the previous month and complete the monthly analysis report.

5. Place of meeting: The place of meeting should always be the hospital, where the medical records, X-ray films, reports, and patients are available for demonstration. Meetings held outside the hospital are never so successful.

6. Duration of meeting: The meeting should start and end as nearly on



time as possible and must not consume a period unduly long and irksome. When a meeting lags, the physician's time is wasted and his interest is lost.

7. Rules of procedure: Parliamentary rules of procedure should govern the meeting, but should not be so strictly enforced as to preclude discussion. Free and frank discussion from the floor should be encouraged.

Unless the medical staff conference is properly conducted, a good attendance cannot be expected. Leadership on the part of the chairman is essential, in fact, the type of chairman may make or ruin the medical staff conference—a fact which the medical staff sometimes fails to consider when appointing its officers.

#### *Attendance at medical staff conference*

The question of attendance at medical staff conferences is one which should receive serious consideration. Every physician who attends patients in the hospital, whether he centralizes all his work in the one institution or has only an occasional patient in several institutions, should attend the staff conferences and take part in the discussions for the benefit of his present and future patients, and to increase his own knowledge.

As to those who can attend the medical staff conference, this depends on the community, the activity of the medical organizations, the number of hospitals in which the physician works, his social or community obligations, and the wishes or inclinations of the individual physician. A physician who has many hospital connections, is a member of all the medical societies, and has numerous other meetings or obligations may not attend medical staff meetings regularly. However, it is rarely desirable or necessary for him to have so many hospital connections; rather, he should limit these to the institutions in which he can show an active interest.

There is one group whose attendance at medical staff conferences is obligatory—the active medical staff. In making this rule and enforcing it the governing board, supported by the medical staff, must take a firm stand. Members of the active or attending medical staff should have no other active staff connection and should be required to attend all staff conferences unless able to present an acceptable written excuse. Three excuses are acceptable: illness of the physician or his family, absence from the community, or the occasional emergency.

In some instances a physician or surgeon may be a member of the active, associate, or courtesy staff of one or more hospitals. It is preferable that a physician limit his active medical staff membership to one hospital and not more than two at any time. He may, because of his clientele, be on the associate or courtesy staffs of other hospitals. It would, therefore, be difficult for him to attend all meetings of the medical staffs and in such cases more latitude is generally given in the matter of regular attendance. The American College of Surgeons does not want to be unreasonable in this respect by requiring a doctor to attend four, five, or more staff conferences a month when possibly he has had but little work during this period in one or another of these hospitals. However, all should be invited and urged to attend, especially where they have the most work. There is one condition which should be obligatory and that is, when the program committee has selected any case belonging to a member of the associate or courtesy staff, he should be notified of this fact in sufficient time to enable him to come prepared to present the case in summary. If he is unable to be present, a justifiable excuse is acceptable, and if possible and practicable, the case should be presented by someone else so that the program will not be interrupted.

Each physician should have a major hospital, that is, one to which he wishes to attach himself more intimately and do most of his work. If he has to select the medical staff conference he should attend during the month, the one which has his primary or major interest should be chosen. As already stated, he should endeavor to support all of the hospitals where he works and in this respect he can best show his cooperation and loyalty by attending the medical staff conferences and taking part in the discussions.

The hospital should have an effective rule that if a member of the active medical staff is absent for more than three consecutive meetings without an acceptable excuse, and his attendance falls below 75 percent, his membership is automatically canceled. It then becomes the duty of the secretary to report to the medical staff that the absentee is no longer a member of the active medical staff, and to call for recommendations for a new appointment. The physician who has thus lost his membership may be eligible for reappointment, provided further regularity of attendance is assured.

In considering attendance of the associate medical staff it is perhaps unwise to make so strict a ruling, but the members of this group should be required to

attend at least 50 percent of the staff conferences. An accurate record should be kept by the hospital showing the number present at each meeting and the individual's attendance during the year. This latter record is an excellent index of the physician's interest and zeal and is particularly useful when promotions are being considered. If a member of the associate medical staff has not attended at least 75 percent of the meetings, this should be taken into consideration in recommending promotion to fill a vacancy on the active medical staff. A member of the associate medical staff who is not sufficiently interested in the hospital and in scientific medicine to attend the medical staff conferences is not likely to be a very desirable member for the active staff.

Members of the consulting and honorary medical staffs are valuable to the hospital even though they never attend a meeting. However, their value is greatly enhanced if they do attend and give the benefit of their counsel.

#### *Minutes of medical staff conference*

Accurate minutes of all staff conferences should be prepared by the secretary of the medical staff, including the attendance record of each member, reports of committees, brief abstracts of the cases presented, and discussions. The abstracts consist of the hospital number which identifies the patient, a brief statement of salient points brought out in the discussion, and conclusions. It is important that the minutes be prepared in an orderly fashion, preferably typewritten, and kept on file in the hospital for reference and review by the representative of the American College of Surgeons when he is making the regular survey of the hospital. The representative's report to the college concerning the medical staff organization and proceedings is based primarily on the official records of the secretary of the medical staff. The staff minute book designed and recommended by the American College of Surgeons contains indexed sections for bylaws, signatures to the bylaws and anti-fee-splitting pledge, roll call and roster of membership, monthly analysis report, special reports, and outline for abstracts of the cases (addendum IV, p. 103).

#### *Advantages of medical staff conference*

Medical staff conferences, properly organized and conducted, are an advantage to the patient, the physician, the hospital, and the community.

1. To the patient: Through the medical staff conference and the resulting medical audit, better service is rendered the patient because the scientific work of the hospital is kept on the highest plane of efficiency. The attending physician leaves undone nothing that will react beneficially. His personal effort tends to become increasingly painstaking and he takes advantage of the consulting service which is made available. Special departments are used as indicated, these departments, as X-ray and the clinical laboratory, being extremely careful that the work is accurate. The operating room staff makes certain that technique is rigidly observed and that it is kept abreast of advances which have been made. In the wards care is more skillful and painstaking. There is a determined and united effort to prevent infection and other morbidity. The consequent lowering of the mortality rate and the shortening of the average days' stay per patient react to the benefit of the individual patient.

2. To the physician: The medical staff conference increases the clinical efficiency of the individual members of the medical staff. It can be a veritable postgraduate course for physicians since it brings before them the newer methods of diagnosis and treatment being used, changing technique in surgical operations, and other facts bearing on scientific progress. The stimulus of the clinical conference is particularly beneficial to the young physician, since it encourages him to further his study and knowledge through reading, postgraduate courses, and other means. Furthermore, fellowship and cooperation are promoted among the members of the medical staff. A good clinical conference tends to eliminate factional strife, unfriendliness, and jealousies by affording an opportunity for the exchange of viewpoints.

3. To the hospital: To the hospital the advantages are threefold. The medical staff conference is a careful analysis of the professional work, revealing weaknesses and emphasizing points of strength, thereby insuring constant improvement. The medical audit made by the staff conference gives the administration and governing board a clear statement of results which may be checked with comparable institutions. All this self-analysis en-



genders a feeling of confidence in the community and this confidence enhances the reputation of the hospital.

4. To the community: To the community the advantages extend into the fields of curative and preventive medicine. Individuals of the community when ill are furnished with a place where their disabilities may be cared for in accordance with the teachings of the most advanced medical thought. Prevention is directed against both noncommunicable and communicable diseases. The systematic examination of individuals, carried on to best advantage by the physician in the hospital, is showing marked results in prevention or early diagnosis of diseases such as cancer. In the field of prevention of communicable diseases the hospital supplements the work of the health department, but the direct community benefit is in the actual care of patients suffering from such diseases, thereby promoting complete recovery and protecting the community against spread of disease.

#### CLAUSE IV OF THE MINIMUM STANDARD FOR HOSPITALS

That accurate and complete medical records be written for all patients and filed in an accessible manner in the hospital, a complete medical record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations, such as consultations, clinical laboratory, X-ray, and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and microscopical pathological findings; progress notes; final diagnosis; condition on discharge; follow-up, and, in case of death, autopsy findings.

##### *Definition of a medical record*

Essentially, a medical record is an orderly written report of the patient's complaint, history, physical examination, diagnostic findings, treatment, and final results. These major divisions are detailed to include the patient's story of present illness, past and family history, findings according to physical examination, laboratory and X-ray examinations, and the use of other diagnostic facilities or instruments, treatment (medical and surgical), notes on progress in the course of treatment, and final diagnosis with end results when determined. The medical record is further supported by the necessary identification data, social history, and nurses' notes.

##### *Necessity for medical records*

Modern medical service has developed procedures in diagnosis and therapy so numerous and extensive that an individual's memory is no longer sufficient to retain the mass of information pertaining to each patient. The modern physician who enlists the services of his associates, such as consulting specialists, pathologist, roentgenologist, and others trained in the numerous diagnostic procedures, expects them to provide him with reports for the medical record, while nurses are required to keep a complete system of charting which is most important. It is equally important that the physician should furnish his portion of the reports necessary to complete the medical record.

In accordance with up-to-date hospital and medical practice, medical records are indispensable from the standpoint of the patient, the hospital, the physician, medical research, and the legal aspect.

As medical records relate to the patient, every illness, even though of a minor character, involves study and examination to the extent that it is impossible for any individual to keep all this detail in mind; the written record, then, is evidence that the patient's case is being handled in a systematic and intelligent manner. Also, the patient may be readmitted with the same or another illness to the same or to another hospital, and another physician may be called in attendance. The medical record of the former hospitalization, if accurate and complete, will be useful to the patient in any future illness. Some examinations need not be repeated and at times dangers are indicated which may be avoided. Complete medical records will often facilitate prompt and proper care of patients, a factor which may determine life or death.

From the standpoint of the hospital, the medical record is a document of facts which contains statements by trained observers of conditions found and results of treatment, and which indicates whether or not the efforts of its physicians supplemented by hospital facilities are in accordance with reasonable expectations of present-day scientific medicine. A medical record is in fact a case study. The hospital is responsible for the results of its service, and only



from the medical records can there be made an analysis of the immediate results, the reasons therefor, and the quality and quantity of work done.

From the standpoint of the physician, the medical record supplies information which he cannot remember, furnishes material for study which will add to his medical knowledge, and assists him in any legal defense. In the education of the medical student and also in the informal education of the physician, the medical record is a recognized necessity. As the members of the medical staff engage in the periodic review of their work, they study in detail the successes and failures in the institution; they compare their own results with those produced elsewhere and with general averages; and they inquire into reasons for the results, whether they be above or below the averages. Surely, the use of medical records along these lines provides a valuable supplementary course of postgraduate education.

In the field of medical research, medical records are indispensable inasmuch as the accumulation of accurate data for study makes it possible for investigators to establish more exact conclusions. While experimental studies yield a certain amount of knowledge, medical records supply a practical and reliable source of material for the advancement of medical science. Every physician in every hospital is in a position to contribute to medical knowledge by means of accurate scientific records.

From the legal aspect, the medical record is of great value, both to the physician and the hospital. The position of both is strengthened by the record which was written at a time when there was no thought of legal action.

#### *Requirements for a system of medical records*

The American College of Surgeons does not undertake to state the exact manner in which hospitals must organize and operate their records departments, but a study of the subject has shown that the following principles are basic requirements for an efficient department of medical records:

1. Medical records room and equipment: The medical records room should be conveniently located, adequate in size, and equipped with the necessary desks, typewriters, filing cabinets, and supplies, including record forms. In small hospitals these facilities may be readily combined with those in the business office.

2. Personnel: The employment of a trained, tactful, and industrious medical-records librarian is most essential. Hospitals would be well guided in the selection of medical-records librarians by employing those who possess the training outlined, and who are registered by the American Association of Medical Record Librarians. Too often the problems of a medical-records department are unsolved or the difficulties increased by untrained and inexperienced personnel. In the large hospital she will need assistants to carry on the work properly. In the small institution where the employment of a full-time medical-records librarian is not wanted, one of the hospital employees who is familiar with the records system could be assigned to this work and allowed sufficient time each day to fulfill the required duties.

3. Plan to secure medical records: Every hospital should make some definite plan to secure medical records. One of the following methods is generally used:

- (a) The attending physician may, of necessity, be required to provide the medical record himself when the hospital is unable to furnish assistance.

- (b) The intern writes the medical record which is checked and signed by the attending physician at the time the patient is discharged.

- (c) The hospital provides a medical secretary or stenographer to whom the physician dictates his reports.

- (d) The physician dictates to the dictaphone the medical record which is transcribed by a typist.

The hospital should give the physician all assistance possible to relieve him of detail work, but it cannot relieve him of the responsibility of providing a complete medical record.

4. Supervision of medical records: The following order of supervision will be found helpful in securing acceptable medical records:

- (a) The physician in charge reviews the medical record when the patient is discharged, makes any corrections or additions necessary, and affixes his signature as an indication that it is complete, accurate, and approved.

(b) The medical-records librarian checks the material in the chart to see that all component parts are included and properly assembled for the permanent file, but she should not be expected to judge the quality of the contents.

(c) The medical-records committee reviews the medical records regularly for the purpose of appraising them and making a report to the medical staff at the monthly conference. In judging the quality of the clinical data recorded in the medical record the committee should note that all expressions of opinions are supported by findings. The objection to the use of "negative" and "normal" is that too frequently these terms are used as opinions to avoid acknowledgment of the fact that the region or system was not examined with sufficient care to produce a detailed statement of findings.

5. Record file and index: A system of filing and indexing according to one of the acceptable nomenclatures should be adopted. This subject will be discussed under a subsequent topic. Four indexes are required, namely:

(a) Patient. (b) Disease. (c) Operation. (d) Physician.

6. Preparation of monthly report: One of the duties of the medical records department is the preparation of a monthly report to present to the medical staff conference. This includes:

(a) A monthly review of the work done in the medical records department showing particularly the status of the medical records relative to improvements as well as deficiencies noted.

(b) A summary of the hospital services according to the monthly analysis outline recommended by the American College of Surgeons.

Finally, and of equal importance, a successful medical-records department depends upon the combined efforts and interest of the hospital management, of the personnel, and of the medical staff.

#### *Contents of a medical record*

A complete medical record is composed of three sections:

1. Sociological: Identification data and sociological information secured by the admitting official and the social worker should become part of the patient's record inasmuch as such facts have a bearing on the care of the patient.

2. Nurses: A graphic chart of symptoms, record of treatment ordered, and of treatment and diet given.

3. Medical: Written, dictated, or prepared under the supervision of the attending physician.

An outline of the content of a complete record follows:

1. Identification and sociological data: Name of hospital; name, address, and address of nearest relative or friend; name of attending physician; number of patient; color; date of birth; occupation; nationality; religion, and dates of admission, operation, and discharge.

2. Complaint: The patient's statement of reasons, signs, and symptoms for seeking medical aid.

3. Present illness: The patient's story of the onset and course of the disease beginning with date, mode of onset, together with subjective signs and symptoms of diseases or injuries up to the day of admission, including a statement of treatment given.

4. Past history: A summary of the patient's life in relation to pathology, illness, with or without complications, operations and injuries, habits, social condition, environment, and any data which may be related to the present illness.

5. Family history: Information relative to evidence of hereditary or infectious diseases and familial tendencies to disease.

6. Physical examination: Facts pertaining to the physician's actual findings as a result of a thorough examination of the patient and a detailed description of the regions and systems of the body. The terms "negative" and "normal" are opinions, not facts, and should not be used except in summing up facts which have been stated.

7. Special examinations: Reports of adjunct diagnostic facilities in the hospital, such as consultations, and clinical laboratory, X-ray, and other findings.

8. Provisional diagnosis: A statement of the probable pathological conditions to be recorded after the preliminary examinations have been completed and before any surgical operation is undertaken.

9. Treatment, medical or surgical: A record of all orders for medicine, treatments, and diets. If operated upon, the preoperative diagnosis should

be written prior to the operation. A full description of operative procedure and findings, normal and abnormal, and of all organs explored should be recorded, followed by a postoperative diagnosis and a report of the anesthetic, together with a statement of the patient's post-anesthetic condition.

10. Pathologist's report: A complete description, gross and microscopic, and diagnosis, of all tissues which are removed at operation.

11. Progress notes: Specific statements by the physician relative to the course of the disease, special examinations made, response to treatment, new signs and symptoms, complications, and in surgical cases, removal of drains, splints, and stitches, condition of surgical wound, development of infection, and any other data pertinent to the course of the disease. The frequent use of general statements, such as "condition fair," "general condition good," and "no complaints," is unscientific and valueless.

12. Condition on discharge: A definite description of the patient's physical status, with positive or negative evidence of persistent symptoms which provide a prognosis and indications of fitness of the patient to return to his mode of living, also orders to the patient to be followed on his return home and instructions for follow-up, if indicated.

13. Final diagnosis: Recorded when determined together with secondary and associated diagnoses in the order of their importance.

14. Follow-up records: Concise notes made at subsequent visits of the patient or from subsequent reports on the condition of the patient to determine end results of treatment and to appraise the work of the institution.

15. Autopsy findings: In case of death and post-mortem examination, a full description of the findings should be included with the record.

16. Nurse's record: Graphic chart, physician's orders, record of treatment, including medication and diet, and symptoms observed.

### *Medical record forms*

Hospital standardization does not specify the use of any one set of forms. However, it does recommend that the hospital select a set of approved forms which are sufficiently outlined to provide a complete medical record but not so completely as to detract from the individuality desired. There is a tendency for some hospitals, usually those with insufficient system and control, to resort to the use of detailed outlines in the effort to secure adequate medical records. Each institution should have a well organized medical records system and should adopt a carefully selected set of forms which are the most suitable; each record should be made to fit the case rather than for the case to be made to fit the record.

### *Arrangement of a medical record*

The most convenient order of the various forms of the medical record used during the patient's stay in the hospital is as follows:

1. Graphic chart.
2. Orders for treatment.
3. Nurse's record.
4. Reports of special examinations: radiology, laboratory, consultations, and others.
5. Reports of special treatments: anesthesia, operation, X-ray, radium, physical therapy, and others.
6. Medical section: history, physical examination, progress notes.
7. Statistics card.

For permanent filing in the records department, the various sections of the medical record should be arranged chronologically as follows:

1. History.
2. Physical examination.
3. Reports of special examinations and treatment:
  - (a) Radiology.
  - (b) Laboratory
  - (c) Consultations.
  - (d) Anesthesia.
  - (e) Operation.
  - (f) Surgical pathology.
  - (g) Other special reports.
4. Progress notes.
5. Graphic chart.
6. Orders for treatment.
7. Nurse's record.



*Filing of medical records*

Numerical filing of medical records, either by admission or discharge number, is the most common method used by hospitals. For the majority of institutions the use of the admission number is preferable. Under the unit system a number is assigned to the patient on first admission. This same number is placed on the medical record forms of all subsequent admissions which pertain to that patient. Under the serial system the patient receives a new number on each admission, and all previous records may be brought forward and filed with the latest admission number. The discharge number, when it is used, is assigned at the time the medical record is received in the medical-records office and is entered on the pages by the librarian. After the records have been received in the office, properly checked, approved, and indexed, they are placed in a folder or envelope on which is written the patient's number; they are then filed according to that number.

*Indexes*

In order that filed medical records may be available for purposes for which they are compiled, proper indexes should be maintained for:

- |                  |                  |
|------------------|------------------|
| 1. The patient   | 4. The physician |
| 2. The disease   | 5. End results   |
| 3. The operation |                  |

1. The patient's index is made by inserting the name of the patient, name of attending physician, date of admission, and number on a suitable card, and filing it alphabetically. The file used may be a visible or vertical card drawer; the index may be annual or continuous, but the latter is recommended. In most hospitals the ordinary index of alphabetical guide cards may suffice, but in case difficulties in indexing are encountered due to variations in spelling names, a system of coding is simple and has the additional advantage of preventing those who are not familiar with the system from using the files and disarranging the cards. A unit or serial system may be used. In the latter, readmissions are entered on the original index card so that one card carries the numbers of all records of the patient for all admissions.

2. The index of disease is needed to make the clinical record available should one desire to study the clinical data of patients who have been treated for a particular disease. This index may be kept either in the card or loose-leaf form. There are two methods of indexing diseases:

(a) The classified system in which diseases are grouped according to an acceptable nomenclature by topography and etiology.

(b) The alphabetical system, in which all diseases are listed according to the alphabet.

These two systems are known as the Standard Classified Nomenclature of Disease and the Alphabetical Nomenclature. Much attention is being directed to the former system because of its uniformity.

3. The index of operations should list the operations in their respective groups so as to allow a physician to study the records of patients who have been in the hospital for any specific operation. The reference in the index indicates the patient's hospital number, and both the index of operations and the disease index contain the name of the surgeon, the date, and the result.

4. The physician's index is prepared by writing the name of the physician at the head of a page or card which is filed alphabetically. At the time of discharge the patient's number is recorded on the card of his attending physician and the result in its relation to prognosis is recorded in the proper column. By adding these columns the number of good-risk patients who have recovered or died is determined.

5. The index of end results can be made according to the following classification:

<i>Elective</i>	<i>Emergency</i>	<i>Palliative</i>
(a) Good	(a) Good	(a) Good
(b) Fair	(b) Fair	(b) Fair
(c) Bad	(c) Bad	(c) Bad

This prognosis should be reviewed by the medical staff to insure correctness. At the time of discharge the immediate result is stated and is accepted as a criterion until such time as the end results can be secured. As the hospital has the acknowledged responsibility of assuring itself and its patients that the members of its staff are competent in their respective fields, no accurate means exist for judging competence unless a record of the work of each member, together with the results, is kept, indexed according to a plan such as that suggested above. (For full details, see addendum II, pp. 98-101.)

### *Uses of a medical record*

As a personal document, the medical record can be used only for the patient himself. It is generally conceded that the patient has the right to the use of his own record, but that no other person should have access to it without his specific orders. It is the history of the patient as given to his physician, and both legally and ethically it has the same status as a verbal communication. In fact, it is that confidential information in written form. Therefore, if it is to be used, it is advisable to secure the consent of the attending physician whenever this is possible. If a second physician is called in, that physician is regarded as having the patient's permission to use the record. It is giving one physician information which has been secured by another, but this privilege is reciprocal. If the first physician, for justifiable reasons, objects to releasing the record to the second physician, his wishes should be respected. A legal point that must always be recognized is that an acceptance of a subpoena requires that a representative of the hospital must take the medical record to court, otherwise the hospital is liable for contempt of court. Cooperation with attorneys in the legal use of a medical record will result in reciprocal consideration which will save much time and trouble.

The medical record as a personal document is not available for insurance companies, compensation boards, or similar organizations except with the written consent of the physician and the patient. When a patient requests a hospital to complete a sick claim, that request gives the hospital the right to use the record and divulge its content. As there may be some variation in the law, the administration of each hospital should know the specific laws pertaining to medical records, if any, in the respective State or province.

In case of death the legal executors of the estate are considered the personal representatives of the patient and as such they should have access to the medical records insofar as necessary for performance of their duties. When the legal representatives of an estate request a death certificate for an insurance company, the hospital should execute the certificate and have it signed by the attending physician.

As an impersonal document, the medical record is available for the monthly review of the work of the hospital as recommended by the American College of Surgeons in the Analysis of Hospital Service (addendum VI, pp. 106-107), and for scientific research in any form.

In review and analysis care should always be exercised that the medical record being used does not identify the particular patient. It is true that in many uses of the medical record for hospital purposes the preservation of the impersonal character is nominal, since the name is on every page. The intention can be fully carried out, however, since the record is used only by physicians and others who are bound by the code of professional conduct.

In the use of medical records for special study and research, members of the medical staff are permitted access to the records. If publication is intended, permission should be secured to use the record, as the member of the medical staff who was originally responsible for securing the information may be writing a similar article at the same time. Thus, proper courtesy should be shown toward each other by the members of the medical staff. If a physician who is not a member of the medical staff wishes to use the records, he must secure the consent of the attending physician, and as the hospital is custodian of the records, it is customary to obtain also the consent of the superintendent.

In the legal use of the medical record the hospital must also practice caution. The record cannot be shown to any person without authority of the attending physician and the patient, except upon subpoena from the court, in which case the hospital is under legal obligation to produce the record in court.

### *Nurses' records*

The nurses' records consist of the graphic chart, the physician's orders for treatment, the record of treatment and diet given, and a record of observations and symptoms. The forms used have a heading consisting of the hospital number, name of patient, number of room or ward, and name of attending physician. The graphic chart contains a record of the pulse, temperature, and respiration with the date and hour noted. Likewise, notations of stools and urine may be entered in the allotted spaces on the graphic chart. All orders for treatment must be in writing. When a physician is obliged to give orders by telephone, they should be received by a responsible, experienced person who will record them correctly with signature. Such orders must be countersigned by the physician on his next visit to the hospital. Orders written by the physician are copied by the nurse



on the special form and kept as a record of treatment ordered. As these orders are executed by the nurse, she makes the appropriate notations on another form, the "nurse's record." This form contains also the nurse's report of what she has done and what she has observed, prefixed by the date and time of each entry, and her signature.

Nurses' notes should be carefully compiled and filed permanently with the rest of the medical record as they are one of the best indications of quality of service rendered. Though nurses' notes may in some instances be rather voluminous, the question of sufficient space for permanent storage need not be raised if an economical method of storage is provided. This presupposes the preserving of the medical record in an envelope or folder and the storing of the latter compactly on shelves arranged in double tiers from floor to ceiling, 24 to 30 inches apart. While it is the practice in some hospitals to destroy nurses' records after the patient is discharged, the American College of Surgeons is convinced that these records, if properly prepared, are worthy of preservation, since they contain much detailed information not found in other sections of the chart and serve to round out the patient's record.

#### CLAUSE V OF THE MINIMUM STANDARD FOR HOSPITALS

That diagnostic and therapeutic facilities under competent medical supervision be available for the study, diagnosis, and treatment of patients, these to include at least (a) a clinical laboratory providing chemical, bacteriological, serological and pathological services; (b) an X-ray department providing radiographic and fluoroscopic services.

##### *Minimum Standard for Clinical Laboratories in Hospitals*

1. Supervision. The director of the clinical laboratory shall be a graduate of an acceptable college or university of recognized standing, and shall have had adequate training in clinical pathology or allied subject. In case the director is not a physician there shall be attached to the laboratory a graduate in medicine competent to render diagnoses on pathological conditions.

2. Functions: The clinical laboratory shall be prepared to perform satisfactory work in (a) pathologic anatomy, gross and microscopic; (b) bacteriology and parasitology; (c) serology; (d) hematology; (e) chemical and morphologic examinations of other body fluids, exudates, transudates, and excreta.

3. Examination of tissue: All tissues removed at operation shall be sent routinely to the clinical laboratory for examination and report.

4. Records and reports: A readily available copy of all reports shall be filed in the laboratory and one with the patient's record. In pathologic anatomy there shall be in the laboratory a cross index of, at least, the name of the patient, of the hospital or laboratory number of the patient, and of the lesion or organ. There shall be preserved also, for at least 3 years, either section, imbedded tissue, or gross specimen from each case from which tissue possibly showing pathologic change is removed.

5. Charges: A uniform system of charges for laboratory work shall be adopted.

6. Conferences: The clinical pathologist shall attend and participate in the medical staff conferences of the hospital.

##### *Clinical laboratory*

The clinical laboratory occupies a major position among the diagnostic and therapeutic services in a modern hospital. While these facilities may vary in each institution, depending upon the size of the hospital, its resources, and the ideals of the medical staff, they must be such as to assure the scientific care of every patient. Recognizing this premise and the fact that every hospital which maintains a well-organized clinical laboratory service will go far in making accurate diagnoses and giving proper treatment, the American College of Surgeons in 1926 formulated a minimum standard for clinical laboratories in hospitals in order to promote the development of these facilities along the right lines. This minimum standard is given above. The requirements are simple but fundamental, are applicable in a practical manner to the clinical laboratory in any hospital, and, if properly carried out, will assure an efficient service.

Special care should be exercised in selecting space for the clinical laboratory which is adequate in size, properly lighted, well ventilated, and situated conveniently for contact with the medical staff. The practice of placing the



clinical laboratory in a dark corner in the basement or in out-of-the-way places for which no other use can be found is ill advised.

A growing practice in hospital planning at the present time is the grouping of various diagnostic units, including the clinical laboratory. They should be located in the most convenient place, generally found to be the first or ground floor. In some hospitals they are located in close proximity to the operating rooms. Some of the larger hospitals place small supplementary clinical laboratories on the various floors in addition to the central laboratory, and equip a room adjacent to the operating rooms for biopsies and the immediate examination of gross pathology.

As to the physical requirements no figures can be given for the size of the clinical laboratory, since this will depend entirely upon the extent to which laboratory work is done within the hospital. The small hospital which does only routine examinations in its own laboratory, sending all tissues and the more complicated work to a consulting laboratory, can do very well with a minimum of 100 square feet of floor space. As the hospital increases in size and the clinical laboratory enlarges its scope, the physical facilities are increased proportionately until in the largest hospitals the most complete equipment and extensive group of rooms, which are strictly departmentalized, are found. These large laboratories usually have a central office for administration and a central workroom in which provision is made for such facilities as may be utilized in common for all departments. Grouped conveniently near the central office are the subdepartments for all special types of work; each room is especially equipped for its particular type of work. Subordinate to the main laboratory is a small pathological laboratory located adjacent to the operating rooms, where there are a microtome, a microscope, stains, and other necessary equipment for making examinations of surgical tissues.

Laboratory equipment will vary from the simplest requirements for doing routine examinations and preparing other specimens to be sent to the central laboratory to the complete equipment found in the largest hospitals. The equipment has been well standardized, and its selection should be left to the director of the laboratory in consultation with the administrator of the hospital.

*Supervision.*—The principles of hospital standardization require that the clinical laboratory be under competent medical supervision with adequate personnel:

1. **Director:** The prime requisite for a successful and reliable clinical laboratory service is the selection of a well-qualified director. Preferably, he should be a graduate of an approved medical school, licensed, ethical, in good standing in his profession, and specially trained in clinical microscopy, chemistry, serology, bacteriology, pathological histology, and gross morbid anatomy. He should be qualified to take his rightful place as a member of the medical staff, to serve as a consultant, to attend all medical-staff conferences, and to participate in the programs. Members of the medical staff should not hesitate to request his services at the bedside or in the operating room, as well as in the clinical laboratory, when he is desired in consultation. Under certain circumstances, the director of the clinical laboratory may be a graduate of an acceptable college or university and have had adequate training in all phases of laboratory work. In such instances, a graduate of medicine, competent to render diagnoses on pathological conditions, should be employed.

2. **Assistants:** The large hospital requires, in addition to the medical director, certain qualified assistants to take charge of special fields such as chemistry, serology, and bacteriology. While these assistants should have the necessary preliminary education, preferably graduation from an accredited college, they need not necessarily be graduates of medicine, provided they are trained and competent to carry out the laboratory procedures in their special divisions.

3. **Technicians:** Technicians should have training and experience sufficient to assure the hospital that they are competent to do the work assigned to them. An erroneous laboratory report is misleading and is worse than no report at all, inasmuch as treatment may be influenced to the extent that the welfare of the patient is actually jeopardized. The policy of entrusting laboratory technique to nurses and others who have had limited practical training or insufficient technical education and experience, usually obtained in a short course, is condemned. In the selection of technicians, hospitals must carefully investigate their credentials. A most reliable criterion of training and experience is recognition by the Registry of the American Society of Clinical Pathologists. The American College of Surgeons recom-

mends that clinical laboratory technicians who are employed by hospitals to fill positions of responsibility be registered by the above-named society. As an alternative, the requirements of a clinical laboratory can be met by:

1. A full-time clinical pathologist, especially in large hospitals where the volume of work warrants such employment.

2. A part-time clinical pathologist in smaller hospitals where there is not enough work to warrant the employment of a full-time director. Oftentimes arrangements can be made for a pathologist to serve two or more hospitals when each has a competent technical staff and the pathologist can make rounds at regular intervals to examine the tissues, make special examinations, and supervise each department.

3. A consulting pathologist, to whom materials may be sent for diagnosis and who will come to the hospital laboratory periodically to supervise the service and meet with the medical staff.

4. A member of the medical staff who has had training in clinical pathology, to direct the laboratory where a pathologist is not available or the volume of work, as is often the case in small hospitals, is insufficient to warrant the employment of a specialist in this field. In these hospitals, such as the small, isolated institutions, tissues for diagnosis and similar examinations requiring more extensive equipment and skill will be sent to the nearest available complete clinical laboratory. The consulting laboratory should be one in which a qualified pathologist is in charge.

*Functions.*—The clinical laboratory must function in such a manner as to meet the varied demands of the hospital from the standpoint of affording every member of the medical staff facilities which will enable him to make a comprehensive diagnosis of every patient. In certain cases the laboratory should assist the members of the medical staff in the therapy which they order. To this end the laboratory should give a very broad service covering:

1. Gross and microscopic pathology.
2. Bacteriology and parasitology.
3. Serology.
4. Hematology.
5. Chemical and morphologic examinations.

The practice of accepting reports of laboratory examinations made outside the institution when there is a reliable clinical laboratory service within the hospital is not good policy. While it is true that some of the aids in laboratory diagnosis are such that they can be provided readily by the physician for his own personal use, others involve so great an investment of capital, require so much space for their accommodation, and demand personnel so highly trained to carry out the examinations, that it is economically unsound for each physician to provide and maintain such aids as a part of his private equipment. Therefore, these facilities are centralized in the hospital where every physician in the community may have access to them for the benefit of his patients. The volume of clinical laboratory examinations concentrated in a hospital reduces the unit cost, provides for more complete facilities, and enables the department to maintain efficient service by its ability to employ well-trained personnel. Clinical laboratory reports from outside are acceptable only if they come from an approved laboratory. The hospital must have a clinical laboratory and in order for it to exist and render acceptable service the members of the medical staff must give it their support.

The value of clinical laboratory service cannot be overestimated, and the extent to which it is utilized is one of the important criteria of thorough diagnostic work. The clinical laboratory in every general hospital should be authorized to make at least a urinalysis for all patients on admission to the hospital; also, blood-cell counts and estimation of hemoglobin are examinations done so regularly that they are practically routine examinations in hospitals having well-organized laboratory service. Blood-clotting time should be done for all tonsil and adenoid cases and for suspected bleeders. While a blood test for syphilis may not be indicated as an absolute routine procedure, the importance of this test is sufficient to place it in the list of frequent rather than an unusual examination. These examinations give a clue to so many common diseases and supply information which is indispensable to the thoroughgoing physician. The positive findings are invaluable in the treatment of disease, and the negative findings are equally important, especially in differential diagnosis.

One of the most important functions of the clinical laboratory of any approved hospital should be an adequate bacteriological service for all departments of the hospital. The laboratory should control and continually check all apparatus for



sterilizing materials that are used throughout the hospital, particularly for the operating room and the supplies prepared for the surgical operations. There should be a periodic control of the sterilizers by the utilization of a resistant spore-forming organism, such as *B. subtilis*, which should be used as a test organism for the complete sterilization of the materials. In any infectious disease the causative organism should be determined as soon as possible in order that prompt, efficient, and specific treatment may be administered and further spread of the infection avoided. This is particularly true on the medical service in the care of the pneumonias, the dysenteries, including typhoid, and in nonsterilizing hemolytic streptococcus infections. Likewise on the surgical service proper treatment depends upon an early identification of the causative organism, especially in such cases as accidental wounds in which tetanus or gas gangrene may develop or in such infections as suppurative arthritis, osteomyelitis, or septicemia.

The laboratory should operate on a 24-hour basis and must be equipped so that every kind of pathogenic organism, including the anaerobic bacteria and the fungi, may be identified at any time. All types of media necessary for isolation and identification must be available and the cultivation of bacteria as isolated colonies on solid media, both aerobically and anaerobically, is essential. Furthermore, the intern staff should be trained to perform the emergency examinations when they are required. Exudates, such as peritoneal, pleural and joint fluids, as well as the exudate in suspected cases of gas gangrene, should be examined directly. In many instances bacteria cannot be cultivated from exudates if they are retained overnight in the ice box and such delay may result in grave injury to the patient.

Other routine examinations may well be established for certain groups of cases, for example, sputum examinations on all pulmonary cases, throat cultures on all children, a test for syphilis on all chronic and obscure conditions, and a stool examination on all gastrointestinal cases.

*Examination of tissue.*—Every piece of tissue removed at operation should be sent to the pathologist for gross or microscopic examination and report. In addition, when it is deemed advisable, the pathologist should make a microscopic examination of all tissues to elucidate or confirm the diagnosis. The importance of surgical pathology cannot be overestimated. The pathologist's examination gives additional information through microscopic study or corroborates the surgeon's impression in making a final diagnosis, all of which fully justifies the examination in every case. The pathologist occupies a position of consultant rather than detective and should be called to the operating room whenever it is advantageous for him to see the gross specimen in situ.

*Records and reports.*—Although there have been no arbitrary regulations adopted relative to the details of keeping laboratory records, all reports of findings should be filed and cross indexed. The following filing system is suggested:

1. Requisition for work desired: This form should be applicable for all examinations. Ample space for a brief abstract of clinical data is desirable in order that the work of the pathologist may be facilitated and that he may give a more intelligent service.
2. Report of findings: This is required to be made in duplicate, one copy to go to the patient's file, the other to remain in the department.
3. Daily, monthly and annual reports: The daily report shows the various consecutive examinations made each day. This may be recorded in a loose-leaf system from which a classified monthly report is compiled. An annual report should be prepared by summing up the 12 monthly reports.
4. Filing of reports: Usually the vertical folder and cabinet are used for the filing of the report, arranged alphabetically or according to the patient's number.
5. Cross index: Many methods of cross-indexing laboratory reports are in vogue. A good system makes it possible to find data by name and by number, and provides the necessary grouping of types of examinations and findings.

Frequently, it is found preferable to assign a clinical laboratory number to each requisition. If this is done, it must not be so placed as to confuse it with the hospital number, which should be carried throughout. Requisitions may be numbered and filed under the physician's name for reference in order that the amount of clinical laboratory work called for by each physician may be readily checked. A summary laboratory sheet for each patient has been found desirable and practical in many hospitals as it saves the physician from searching through many forms.

The use of a clinical laboratory report form consisting of a single page is found to be practicable in many hospitals. This form is divided into spaces with



appropriate headings designed to carry entries of the more common clinical laboratory tests, such as urinalysis, blood, chemical, and bacteriological examinations, gastric analysis, stool examinations, and tissue examinations. A blank space at the bottom of the page with the heading "Miscellaneous" is reserved for listing the reports of unusual tests. Grouping of reports on a single form is convenient for the physician who desires to review all clinical laboratory findings.

In order that there may be centralization of responsibility for examinations and preservation of specimens, it is necessary that all departments of the hospital have instructions to send such specimens to the laboratory regardless of its size or completeness. Exception is made in the case of blood counts and similar examinations in which the technician on receipt of the requisition is responsible for securing the specimens. Each specimen should have a label, properly attached, showing the name and location of the patient, a file number for reference, name of the physician, and character of specimen. All material sent to the laboratory should be prepared for transfer according to instructions from the laboratory, and except in case of routine examinations, a requisition signed by or with the authority of the attending physician must be attached to the specimen.

All tissues should be preserved for review in the event of subsequent developments of the disease, for group study of cases, and for clinical research. Keeping all tissues on hand for a period of at least 3 years will not impose a hardship on the laboratory and will allow time within which most sequelae are likely to occur. Of course, there are many specimens which the pathologist desires to keep indefinitely, such as those which represent a series of cases or the rare and interesting tissues.

*Charges.*—The numerous factors entering into the system of making charges for laboratory service have prevented the adoption of a uniform plan of financing the laboratory. While the American College of Surgeons does not recommend any one of the many plans in use, it urges that every hospital adopt a definite system of charges and that the rates be such that the patients will not be deprived of the service necessary for their proper care.

In some hospitals the clinical laboratory is maintained by an endowment fund or by city, county, State, or Federal appropriations, and the patient is not charged.

*Conferences.*—The clinicopathologic conference is a meeting of the medical staff with the pathologist, designed to study surgical pathology and post-mortem specimens. To fulfill its purpose, this meeting should be held weekly, biweekly, or monthly, as necessary, and should not replace or interfere with the regular medical staff conference. The following program is suggested:

1. Present abstract reports of selected cases.
2. Demonstrate gross and microscopic pathology.
3. Correlate clinical and pathological findings.
4. Compare reports with the literature.
5. Summarize findings and conclusions.

The success of this program depends on the pathologist. He selects material, exhibits specimens, and directs discussions in order to develop the points of greatest educational value. After the report of the case is presented and the specimens are demonstrated, discussion is in order and all members of the medical staff should participate. The clinicopathologic conferences have proved so beneficial to medical staffs of so many hospitals that all institutions having facilities for pathology are urged to carry on these conferences.

#### *Minimum Standard for X-Ray Departments in Hospitals*

1. *Supervision:* The department shall be under the supervision of a competent medical radiologist, assisted by trained technicians.
2. *Location:* The department shall have adequate space and be located most conveniently for efficient service.
3. *Equipment:* The equipment shall be sufficient at least for radiographic and fluoroscopic services.
4. *Protection:* Proper protection of the operator and patient together with adequate lighting and ventilation shall be provided.
5. *Records:* A complete system of records shall be filed in the department.
6. *Storage:* A special storage room, which is approved by the fire underwriters, shall be provided for films.

### *X-ray department*

The science of radiology has advanced in recent years to the extent that it has become a highly specialized field. Likewise, there have been so many changes in equipment and technique that only those with up-to-date training and experience and actively engaged in radiology can expect to render the service required of every approved hospital. Since patients, as well as the medical staff, rely more and more on the X-ray department as an indispensable service in the hospital, nothing less than the above minimum requirements are acceptable for approved hospitals.

*Supervision.*—The person in charge of the X-ray department must be a graduate of an approved medical school, licensed, ethical, in good standing, professionally competent, and specially trained in radiology. Such supervision is necessary not only for the administration and management of complicated technique, but especially for the interpretation of findings, which can be done reliably only by a radiologist. The duties of the head of the X-ray department include regular attendance at medical staff meetings so that he may participate in the discussion relating to his own specialty and cooperate with the medical staff at all times as a consultant in diagnosis and treatment.

Of equal importance is the supervision of radiotherapy by a recognized radiotherapist. If the physician is not skilled in this field of therapeutics, he will likely err in the estimation of dosage to the extent that the treatment will either be ineffective or will damage the patient irreparably.

X-ray technicians should be carefully selected and properly trained at a school where a standard course of instruction of at least 1 year is maintained. They should be under the supervision of recognized radiologists who are qualified for registration. The American Registry of X-ray Technicians, sponsored by the Radiological Society of North America, has formulated reasonable standards for technicians, and it is recommended that hospitals adopt these standards which constitute the qualifications for registration.

The duties of the technician consist primarily of operation of the X-ray equipment, development of films, and filing of records. The technician should never attempt to extend his or her work to the field of diagnosis. The responsibility of interpretation is the work of a physician as it constitutes medical roentgenology, a branch of medicine. The technician's interest should be centered on the care and operation of the X-ray equipment with the desire to achieve the greatest proficiency in roentgenographic technique. This requires a knowledge of applied electricity, the physics of light, the care of equipment, and sufficient learning in anatomy to adjust the patient properly for examination. Therefore, the greatest service a technician can offer is the diligent study and application of the principles of X-ray technology. Deprived of efficient technical work, the efforts of the most skilled radiologist in diagnosis are futile.

*Location.*—The most desirable location for the X-ray department is one which is convenient for both physicians and patients. This may vary considerably in hospitals, depending upon size, space available, and whether or not an active emergency service and out-patient department are in operation. Space on the first floor is practical and desirable from the standpoint of accessibility and convenience. However, a location on the top floor has its advantages and is preferred in many institutions. Placing this department with the other diagnostic units on the top floor in proximity to the urological and fracture rooms is especially convenient. For obvious reasons, the basement is the least desirable location for this department.

Authorities have generally agreed that the minimum floor space allowed for an X-ray room should be 400 square feet. Hospitals of 100 to 150 beds will require at least 700 square feet, while larger institutions will need 1,200 to 3,000 square feet. Rooms should have at least 9-foot ceilings and the operating room should be not less than 15 by 20 feet in size. The space in the X-ray department should be divided to afford an office for the director, a viewing room, a waiting room, dressing rooms, a dark room, one or two rooms for roentgenography and roentgenoscopy, and possibly a room for roentgenotherapy. In the smaller hospitals these rooms may be variously combined.

*Equipment.*—An attempt to list the individual pieces of equipment would be impractical. An adequate service requires the installation of a complete roentgenographic unit consisting of transformer, tube stand, table with a stereoscopic attachment, fluoroscopic equipment adjustable to horizontal and vertical positions, a viewing box, a stereoscope, and a dark room equipped for the develop-



ment of films. A mobile unit is necessary for the care of nontransportable cases which require X-ray service. Equipment for X-ray therapy should consist of a specially constructed unit. Unless a hospital can secure the proper equipment, it would be well for it not to undertake treatments of this nature.<sup>1</sup>

*Protection.*—There are three sources of danger in the X-ray department: the danger of electric shock; penetration of the X-rays; combustion of stored films. To insure proper protection, hospitals are advised to acquaint themselves with the recommendations of the safety committee of the American Roentgen Ray Society.<sup>2</sup> Observation of these regulations will tend to prevent accidents of this nature. The increasing use of shock-proof equipment is most helpful in preventing accidents to patients, and to workers in the X-ray department of the hospital.

When it is necessary to administer an anesthetic for an X-ray examination, it is best to have this done outside of the room where the equipment is to be used. If additional anesthetic is required in the course of the X-ray, all circuits must be closed off, the room ventilated as much as possible, and ether or anesthetic material with mask or other apparatus removed before the current is turned on. Every precaution should be taken to eliminate from the room fumes which might ignite when the current is used.

*Records.*—A written report should be made in duplicate of all X-ray interpretations and treatment, one copy to be attached to the patient's record and one filed in the X-ray department. The filing system should consist of—

1. A file for the reports, identified by name and number.
2. A cross index according to the pathology found.
3. A film file in which all films are placed in a cabinet or on a shelf by the number which is identical to the one recorded on the X-ray report.

With reference to ownership of the X-ray films, authorities generally agree that the roentgenograms are the property of the hospital and constitute part of the record system. The films should not be taken from the hospital unless subpoenaed by the court and accompanied by an authorized person from the hospital. No one should have access to the films except the radiologist, the attending physician, and authorized hospital officials.

As to the length of time X-ray films should be kept, the general opinion prevails that all films should be preserved for at least 5 to 7 years for subsequent reference from the clinical standpoint and for medicolegal purposes. Negatives which are suitable for a film library and of value for research purposes should be preserved indefinitely. According to the law in some States, hospitals are required to keep their films on file for a given period of 2 years or more.

*Storage.*—In any system used the films should be filed numerically. Since cellulose acetate films have replaced the highly explosive nitrocellulose product, elaborate precautions in storage are no longer demanded. But even with these films it is necessary to establish definite safeguards against fire. Hospitals are advised to keep only a small supply of negatives on file in the X-ray department. Suitable storage for the old films can be arranged in an outside room or in a detached building without much expense for structural changes. New construction in hospitals should provide for a properly planned storage vault.

#### ADDITIONAL DEPARTMENTS AND SERVICES

In the foregoing pages the five basic or main clauses of the minimum standard for hospitals have been explained in detail. Complying with these requirements effectively is contingent on the proper organization and function of the various departments and services involved in the complete care of the patient. In order to assure this, every approved hospital, as far as practicable and possible, must endeavor to meet the requirements as described in the following pages and applying to the different departments and services concerned in the diagnosis and treatment of the sick and injured. The various minimum standards developed throughout the text will be found to be of practical value in the organization and administration of every approved hospital.

#### *Medical department*

The medical division in the hospital is divided into specialties though not to as great an extent as the surgical department. The more common diseases, as pulmonary tuberculosis, nervous and mental disorders, and communicable dis-

<sup>1</sup> For further information on X-ray equipment see Hospital Standardization Report of the American College of Surgeons, 1930, pp. 27-28.

<sup>2</sup> Bulletin of the American College of Surgeons, 1925, ix, No. 97-98.



eases, are usually treated in separate departments or special hospitals. Because other medical conditions are not so readily divided into specialties, it is only occasionally that they are treated in special departments. However, as a result of investigation and research, medical specialties have been gradually developed and may be departmentalized, especially in the larger hospitals. (Departmentalization, embracing the full range of clinical specialties, is outlined in detail on page 15.)

Well equipped departments of clinical laboratory and radiology will go far to meet the needs of these services. Supplementary diagnostic equipment which is required includes the metabolometer, the electrocardiograph, and facilities for chemical, bacteriological, and serological studies.

Efficient nursing and dietary services are important factors in the treatment of patients on the medical service. Medical nursing is in itself a specialty inasmuch as many diseases and conditions have aspects which require special knowledge and experience. Patients with communicable diseases, pneumonia, or a cardiac condition require nursing care which differs from that given to the patient with anemia, diabetes, or nephritis.

The dietitian is an invaluable aid in the care of medical cases which require proper preparation of diet ordered by physicians, determination of the actual amount of food consumed by patients, and the working out of special diets.

The hospital should encourage consultations by members of the medical staff, by the general surgeon, and by the surgical specialist. This practice will lead to more complete knowledge of pathological conditions; it will insure a more accurate determination of the surgical risk involved, and will result in a higher standard of scientific work in the hospital.

#### *Minimum Standard for Surgical Departments in Hospitals*

1. Administration: The administration of the surgical department shall be under the direction of a competent registered nurse who has executive ability and who is specially trained in operating room management, with an adequate number of assistants and other personnel to carry on the work of the department efficiently.

2. Supervision: The surgical division of the medical staff shall be so organized as to exercise adequate supervision and definite control over the surgery done in the hospital. This presupposes a chief or head of surgery who shall be responsible for general supervision of the professional activities of the department.

3. Coordination: The coordination of effort among the members of the surgical staff and with the personnel shall be such as to promote desirable teamwork and a highly efficient service.

4. Nursing: The widespread custom of using student nurses in the operating room in hospitals which have schools of nursing is sanctioned inasmuch as it is part of their fundamental training, but exacting supervision by graduate nurses is essential at all times.

5. Preoperative study: Except in an emergency, no major operation shall be performed until (a) the patient has been carefully studied preoperatively, (b) the medical record has been written, (c) the routine laboratory examinations have been completed, and (d) the preoperative diagnosis has been established and recorded.

6. Consultations: The surgical staff shall not only encourage but preferably shall require a consultation in all cases of major surgery, and the findings in each instance shall be duly recorded.

7. Surgical technique: Every precaution shall be taken to insure complete asepsis and good technique, and thorough investigation shall be made of all cases of infection which occur in clean wounds.

8. Medical records: An accurate and complete description of findings and technique of operation shall be made by the surgeon in the operating room immediately following the operation.

9. Pathology: All tissues removed at operation shall be sent immediately to the clinical laboratory to be examined and reported upon by the pathologist.

10. Conferences: The medical records of all patients who die postoperatively, present complications, or show unfavorable results shall be thoroughly reviewed and analyzed at the regular clinical and clinicopathological conferences of the medical staff.

## SURGICAL DEPARTMENT

One of the most important units of the hospital is the surgical department which carries a serious responsibility in insuring the efficient care of patients. For the more successful and efficient performance of surgery, the American College of Surgeons recommends that surgical departments in approved hospitals comply with essential requirements which follow.

*Administration.*—The supervisor of the operating room is responsible to the director of nursing of the hospital for the management of this department. She must not only be a registered nurse with special training and experience in surgical nursing technique, but she must possess marked executive ability. On her rests the responsibility for care of valuable equipment; requisition, preparation, and maintenance of supplies; assignment of time for operation; allocation of duties and supervision of the operating-room nursing staff; and teaching pupil nurses operating room technique if a school of nursing is maintained.

*Supervision.*—Every hospital with a surgical department must give careful attention to supervision and control of surgical work if the service is to be kept up to acceptable standards. In the hospital with a departmentalized medical staff the chief of the surgical service is responsible for the professional activities. In smaller hospitals, where there is little or no differentiation in the medical staff, a surgical committee or the executive committee of the staff assists the hospital administration in active supervision of the surgical work.

As to who shall or who shall not be permitted to do major surgery, a license to practice medicine in a State or Province permits the physician to do surgery, but it does not give assurance that he is properly qualified for such work. No definite standard has been formulated which can be applied universally; each case must be decided on its own merits. The problem can be handled advantageously by the medical staff through a duly appointed qualifications committee which will give each case individual consideration. The following suggestions are submitted as a guide to aid such a committee in formulating standards for the better control of surgery:

1. Graduate of an approved medical school.
2. At least a 1-year internship in an approved hospital.
3. Two years or more as a surgical resident or as assistant to a senior surgeon who performs a large amount and variety of major surgery.
4. Two years' experience in doing his own surgery under the supervision of a senior surgeon.
5. At least 6 months' acceptable postgraduate work during the period of 5 years in training.
6. Assurance that the candidate has done at least 50 major operations for which he is the responsible surgeon, all of which have been carefully recorded and show acceptable end results.

These requirements may be amplified or modified according to local conditions.

In the organization of the surgical department the question of surgical assistants at operation is of vital concern. Inasmuch as the surgeon should consider both the safety of the patient and his responsibility for the education of junior surgeons, he should, when operating, have a capable physician-assistant who is competent and ready to carry on the operation at any moment in case of necessity. In order that the assistant may be so qualified he must possess a thorough knowledge of the fundamental principles of medicine. The American College of Surgeons strongly disapproves the practice of having nurses, graduate or student, or others who are not graduates in medicine, act as first assistants. It is the duty of every approved hospital to adhere strictly to the practice of allowing only qualified graduates of medicine to act as assistants at surgical operations in order that patients may be assured the greatest safety possible, that opportunity may be provided for training surgeons for the future, and that the practice of surgery may be developed on a high and ethical plane.

*Coordination.*—Coordination of the activities of the surgical staff and of the operating room personnel respectively is characterized by good teamwork and the sincere effort of every individual to do his or her part to maintain a high grade scientific service. This can be accomplished by making the necessary preoperative study of the patient, calling for a consultation and assistance when indicated, devoting sufficient time to the regular medical staff conference and audit of the work done, agreeing to follow routine procedures and technique as far as practicable, and complying with the regulation of beginning all operations on scheduled time. The reward to the individual who cooperates with



the surgical staff and the departmental personnel along these lines will come to him many-fold in a satisfactory, efficient surgical service.

*Nursing.*—In addition to the supervisor and her registered graduate assistants, the nursing personnel may include student nurses, inasmuch as hospitals with schools of nursing are required to include a course of training in operating-room technique. From the standpoint of safety of the patient as well as instruction, the student nurse must be under careful supervision at all times and must not be entrusted with duties beyond her training and experience. The number of nurses required in an operating room is dependent on variable factors, such as the number and kind of operations done each day, the distribution of operations throughout the day and night, the number of unscheduled operations—such as emergencies—performed daily, and the number of student nurses requiring supervision by the graduate staff.

*Preoperative study.*—Every hospital should rigidly adhere to the requirement that a thorough study of the patient be completed and recorded before any operation, except an extreme emergency, is performed, so that an accurate preoperative diagnosis may be established as a means of determining the operation indicated. Further, the examination will assist in estimating the surgical risk and in deciding the most favorable time for operation.

The evidence of an acceptable preoperative study consists of a complete history and physical examination, supplemented by reports from the diagnostic departments of the hospital and by consultation when indicated. After the preoperative study is complete and the surgeon decides to operate, written authority should be secured. Responsibility for obtaining authority rests primarily with the surgeon, but the hospital has at least a moral obligation to see that the order is made a part of the record. The floor supervisor secures the signed authority to operate if the surgeon neglects to secure it, and the operating-room supervisor checks it as a part of the record before the operation proceeds.

*Consultation.*—No major operation on a patient who is not a good risk and no operation which may interrupt a known, suspected, or possible pregnancy should be done without consultation with a member of the consulting or active medical staff. In case of emergency or when the life of the patient would be endangered by delay, the operation may proceed, but the attending surgeon must be responsible for making a satisfactory statement of the circumstances on the patient's chart.

The custom of having a consultation in all serious cases is becoming more common and in time should be made universal in all cases in which there is any doubt as to diagnosis or treatment. While the trend toward more frequent consultations is praiseworthy, the ultimate goal of the surgical department must include the requirement that all cases in which major surgery is proposed shall have the benefit of a consultation provided by one who is competent to act in this capacity.

When there is any doubt as to the legality or violation of hospital policies, the hospital has the right and the obligation to require consultation. In such cases the consultant should be a specialist in the pathological condition suspected and free from a business association with the physician with whom he is consulting.

*Surgical technique.*—In order to carry out proper technique, the department for the performance of surgical operations requires a special unit physically set apart from all other departments. There should be at least two operating rooms for general use, a sterilizing room, a workroom, a scrub room, and additional operating rooms for the specialists as demands warrant. Each operating room should contain only furnishings and equipment required for the operation to be performed. An exception may be built-in cabinets for solutions, sutures, drains, and supplies which are frequently used and required without delay. When a proper physical unit with adequate facilities is provided, good results may be assured by the establishment of routine procedures as far as practicable and by the use of every precaution to insure complete asepsis.

*Medical records.*—A system of medical records is required for the surgical department and should include a register of operations showing at least:

- |                                |                              |
|--------------------------------|------------------------------|
| 1. Date and hour of operation. | 7. Type of anesthetic.       |
| 2. Patient's number.           | 8. Preoperative diagnosis.   |
| 3. Name.                       | 9. Name of the operation.    |
| 4. Surgeon.                    | 10. Postoperative diagnosis. |
| 5. Assistant.                  | 11. Pathology.               |
| 6. Anesthetist.                | 12. Result.                  |



This register will provide a permanent record of all operations, and it can be kept up daily. Before the surgeon begins to operate, he should record his preoperative diagnosis. Either during or immediately after the operation he should make a detailed report of his findings and his interpretation of pathology, followed by a complete description of operative procedure. Finally, he should record his conclusions or postoperative diagnosis. Some surgeons prefer to have a stenographer in the operating room to whom they can dictate as they operate; others choose to dictate to a stenographer or into a dictaphone at the close of the operation. If neither of these aids is available, the surgeon writes his report himself or instructs his assistant to do so. Any of these methods will result in a good report of the operation, provided it is dictated or written immediately after operation, and read and signed by the surgeon.

*Pathology.*—The examination and preservation of all tissue removed at operation is required. Regardless of whether the tissue is pathological or not, an accurate and complete gross description should be made immediately while the specimen is in a fresh state. After it has been carefully labeled for identification and wrapped in oiled paper to prevent drying, the specimen should be sent at once to the laboratory for examination by the clinical pathologist, accompanied by a copy of the report of operation. This report gives the pathologist information that is valuable in a study of the tissue and enables him to place his record on the same form used by the surgeon. In addition to the gross description, every specimen should have a microscopic examination and report when deemed advisable for the elucidation and confirmation of the diagnosis. One copy of the findings should be kept in the laboratory, and one should be attached to the patient's record. The pathologist's report is of inestimable value to the surgeon, since it confirms the diagnosis or gives additional information of scientific importance.

*Conferences.*—The surgical division of the medical staff may elect to meet as a group to review the clinical work of the surgical department. In the larger hospitals and in those in which the medical staff is more extensively specialized and departmentalized, representatives of certain surgical specialties may desire to meet as a group. In any case, a thorough review and analysis of the work done should be made and should embrace all surgical deaths with reports of autopsy findings when available infections, complications, and unsatisfactory results. It is of particular importance that the pathological report from the operating room, and from the autopsy when available, be presented in connection with each clinical case discussed. Notwithstanding the fact that the members of the surgical staff meet in departmental conference, they should also attend the general medical staff conference. Through such analysis surgical errors can be checked and the efficiency of the service can be generally improved.

### *Sterilization*

A serious responsibility rests upon the supervisor of the operating room or with the individual delegated to the task of sterilizing surgical dressings. The person charged with this important duty must be thoroughly acquainted with the theory and practice of the mechanics of sterilization. She must have complete knowledge of the preparation of supplies, the loading of the sterilizer, and the interpretation of such terms as pressure, temperature, vacuum, etc. The actual work of operating the sterilizing units should be delegated to a trained person of proved dependability.

Efficient sterilization can be assured through the use of modern equipment, competent mechanical and technical supervision, and the application of a reliable method of regular checking of the sterilizers. Many tests have been devised and put into use for the control of sterilizing processes, the more common of which are:

1. Mechanical inspection by the hospital engineer or other trained mechanic, inasmuch as penetration of heat is dependent upon the proper operation of the equipment.
2. Self-recording thermometer for recording on a chart the temperature in the discharge line or the lowest temperature area of the sterilizing chamber.
3. The sterimeter, a combination thermometer and timer for indicating whether or not the desired temperature has been maintained throughout the required sterilizing period.
4. Maximum self-registering thermometer, connected with the sterilizing chamber, for recording the highest temperature in the discharge line but not indicating the time factor.

5. Self-recording pressure gage connected with the inner chamber of the sterilizer for recording the pressure in pounds, the vacuum in inches, and the time of sterilization.

6. Fusing controls placed in the center of each bundle any delay in fusing indicating imperfect sterilization.

7. Color indexes indicating the efficiency of the sterilizer, color changes being dependent upon the temperature.

8. Bacteriological examination of sterilized material in the laboratory by means of cultures.

9. Sterilization of a known culture to test the efficiency of the sterilizer by placing a culture of known bacilli, such as *B. typhosus*, in the autoclave and by making a laboratory examination to recover the organisms after sterilization.

According to recognized authorities on efficient sterilization, the following formula may be prescribed:

Presupposing the creation of a proper vacuum, with steam of at least 15 pounds pressure per square inch, it can readily be seen that sterilization would be safely accomplished by using 15 to 20 pounds' steam pressure and a temperature of 248° F. for 30 minutes.

Some of the afore-mentioned means of testing the efficiency of the sterilizing processes are used singly or in combination, and are mostly confirmatory in value rather than conclusive evidence as to the actual efficiency of sterilization. Research engineers on sterilization have proved conclusively that the most reliable method of controlling or checking sterilizing processes is through recording the temperature in the discharge line of the sterilizer, as this gives the temperature of the coolest part of the sterilizing chamber. This temperature must be maintained constantly at 248° F. or over for 20 to 30 minutes to assure proper sterilization.

The more recently built sterilizers are equipped with a thermometer in the discharge line, but the necessary equipment can readily be added to sterilizers built prior to the introduction of this method of testing and controlling sterilizing processes.

### *Infections*

A definite plan should be adopted for recording and investigating all infections and wounds that are not healing by primary intention. Every infection of a clean wound should be recorded, investigated, and traced to its source. While post-operative and post-partum infections may result from a number of causes or sources, nevertheless, all sterilizing processes must be carefully checked. The following procedure for investigating wound infections is recommended:

1. A note on the healing of all wounds is written on the "wound report" which becomes a part of the medical record.

2. A report of infection is made in triplicate and is sent to the three persons primarily interested—the director of the hospital, the supervisor of the operating room, and the surgeon. The report should be made by the nurse supervisor of the ward and should include name, number, ward, operation (nature and date), surgeon, assistant, instrument nurse, sponge nurse, date of first dressing, dressing doctor, dressing nurse, date infection first appeared, location, and character of infection.

3. On receipt of the report the superintendent, the operating room supervisor, and the attending surgeon are all responsible for making a thorough investigation of the infection and for bringing the information in detail to the medical staff at the time of the regular medical staff conference.

4. The committee of the medical staff concerned with the study of deaths, complications, infections, and other debit items listed on the monthly analysis report should review the cases to determine the sources of infection and whether or not they are institutional. In this manner it is possible to clear up infections and prevent their occurrence in the future.

### *Emergency lighting*

All hospitals should provide some form of emergency lighting service. The extreme complications and tragic possibilities that can result with failure of the lighting system while the operating or delivery rooms, or accident dispensary are in use are too obvious to mention. There are countless occasions when failure to provide adequate protection in this respect has resulted in serious consequences.

The most positive and reliable source of emergency lighting protection is equip-

ment which is installed within the building that is to be protected. There are three types of equipment which are in use in hospitals:

1. Water-wheel generators.
2. Gas engine generators.
3. Storage battery system.

The water-wheel system, as the name implies, being operated by the water supply for the building and dependent on minimum pressure, has the disadvantage of being subject to failure should there be any emergency reduction of water pressure.

The gas-engine generator system is advantageous in hospitals in which it is advisable to carry a considerable number of lamps for a long period of time. When the gas-engine-generator system is used for this purpose, it is advisable also to use a storage battery system to furnish light instantaneously, as the gas-engine-generator system is subject to possible delays in starting which may occur in the case of any gas engine.

Because of the mechanical nature of the foregoing systems, they are probably practical only in those hospitals in which expert engineers are in constant attendance.

Storage battery systems are probably the most commonly used and give more dependable service in the average hospital; and with the improved engineering service which is now available, they are reliable under practically all circumstances. The installation may be fully automatic, the maintenance cost is low, and the only attention required is the addition of water to the battery cells three or four times a year. This system has the advantage of instantaneous response since it is a source of immediate electrical energy, and this is a factor which is of extreme importance when an emergency occurs during an extensive operative procedure.

For hospitals with less than 100 beds, which do not have an extensive surgical service, there is recommended a low voltage unit (12-volt, fully automatic) to which can be attached portable operating lights, and in some cases major overhead lights. This unit should also have sufficient capacity to furnish light for purposes of general illumination in the operating, sterilizing, anesthesia, and delivery rooms and also in the emergency dispensary.

For hospitals of over 100 beds, with their more extensive requirements, a larger storage-battery system is recommended which will operate at the same voltage as the normal supply. Such a system will assure adequate emergency illumination in all of the necessary departments: it is also fully automatic, and it operates in conjunction with the general lighting equipment of the institution.

Emergency lighting installations for hospital use should include fully automatic charge and control units approved by the National Board of Fire Underwriters.

#### *Minimum Standard for Departments of Anesthesia in Hospitals*

1. Department: There shall be an organized department of anesthesia under the direct supervision of a competent medical anesthetist.

2. Personnel: An adequate staff of competent assistants, qualified to administer anesthetics, shall be available to carry on the work of the department.

3. Preanesthetic examination: A complete physical examination of each patient, with clinical laboratory findings, shall be made and recorded immediately before a general anesthetic is administered.

4. Record: A complete record on a prescribed form shall be made of each anesthetic administered. This shall provide data pertinent to the patient's condition previous to and throughout anesthesia, with a notation of preanesthetic and postanesthetic medication and a brief statement of the patient's condition at the close of the operation.

5. Follow-up: Efficient follow-up of all postanesthetic patients shall be maintained to determine results relative to the type of anesthetic used.

6. Safeguards: Definite safeguards in the use of various types of general anesthetics shall be established in view of the known hazards in the administration of anesthetics.

#### *Anesthesia*

The art and science of anesthesia have rapidly advanced since 1842 and 1846 when Crawford Long and William T. G. Morton made their historic discoveries. This work is now carried on chiefly by physicians and nurses who have had special training in administering anesthetics.



The administration of anesthetics is of vital importance because of the effect on the future health of the patient. It is a most influential factor in the end results of surgery and obstetrics, and may even be a cause of death. Anesthesia is a specialty in itself, necessitating special equipment as well as trained and experienced personnel. The department of anesthesia is proficient and up to present day standards only when adequate equipment is provided, qualified and experienced anesthetists are employed, and competent supervision is assured by a medical director specially trained in anesthesia.

The use of local, intravenous, and spinal anesthetics in major surgery should not in any way eliminate the necessity for the presence of a trained anesthetist to stand by in case it is necessary to change to a general anesthetic, as well as to watch more closely the reaction of the patient. This is especially true when using a spinal or intravenous anesthetic. A rule of the hospital should make it imperative that a qualified anesthetist be present when a spinal or intravenous anesthetic is being used.

*Department.*—Every hospital should have a department of anesthesia. Supervision by a medical anesthetist who is responsible for the service is the most important factor in the efficient operation of the department. Due to the increasing number of anesthetics available—general, local, intrathecal, intravenous and rectal anesthesia—the choice of anesthetic is becoming more and more of a problem and requires careful consideration. While the surgeon is primarily responsible for the choice of anesthetic, he may leave its selection to the anesthetist who is well qualified to act as consultant. It is obvious that the anesthesia service cannot function efficiently without the supervision of a competent medical director who has a profound knowledge of this specialty. He must know how to evaluate the work involved, how to chart physiological processes, how to recognize clinical conditions following anesthesia, and how to treat them. In fact, he must be as well equipped with medical knowledge as any clinician in the hospital. Through the efforts of a competent anesthetist, it is possible to reduce considerably the incidence of postoperative morbidity and mortality and to improve the end results.

The custom of allowing the physician who has had only a casual training in the administration of anesthetics, and whose experience is limited to an occasional case, to act as anesthetist without skilled supervision is a dangerous practice. Sometimes when a physician refers a patient to a surgeon for operation he undertakes to administer the anesthetic, and too frequently he is not competent to give it properly. Moreover, in the last analysis, this may only be a subterfuge for fee-splitting. The intern must receive training in anesthesia as in other services, but unless his work is supervised by a skilled anesthetist, his training will be inadequate and an unjustifiable burden of responsibility is thrown upon the surgeon.

*Personnel.*—The personnel in the department of anesthesia must consist of trained, competent assistants. Nurse anesthetists who have specialized in the administration of anesthetics are usually competent and acceptable for the work, but since they are not physicians licensed to administer drugs, they should be under medical supervision. If it is impossible to obtain or maintain a specially trained anesthetist in the community, a member of the medical staff who has had experience in anesthesia might assume the responsibility for supervision and direction of the department of anesthesia.

*Preadesthetic examination.*—The preanesthetic examination as a minimum includes a thorough physical examination, particularly of the heart, lungs, mouth, nose and throat, and blood pressure, and should be recorded carefully on the patient's chart. Reports of laboratory examinations are noted and a statement is made relative to the surgical risk. In case of emergency, at least a rapid examination of the heart and lungs, with blood-pressure readings, is essential.

*Record.*—The record of an anesthetic is written on a prescribed form and becomes part of the medical record. It contains the report of the pre-anesthetic examination described above, preoperative medication, kind and amount of anesthetic used, duration of the anesthesia, condition of patient throughout operation—blood pressure, pulse, and respiration being noted in particular—and, finally, a record of postanesthetic medication, immediate orders of the surgeon, and a statement of the patient's postoperative condition.

*Follow-up.*—The follow-up is the duty of the chief anesthetist who keeps in touch with the patient's condition until all the effects of the anesthetic have passed. He should consult and advise with the surgeon in charge in the event that unfavorable sequelae develop. He should see that all anesthesia records are

kept; these should include a careful correlation of the administration of anesthetics and of the end results. His attendance regularly at staff conferences, where he presents records of his department and participates in the clinical discussions, will do much to stimulate an interest in the important field of anesthesia.

*Safeguards.*—Safeguards in anesthesia must be carefully observed on account of the known hazards that prevail. The National Board of Fire Underwriters and other interested bodies have made a study of these dangers. A summary of some of the more important precautions recommended for consideration are as follows:

1. Storage: All explosive anesthetics should be stored in a fireproof room convenient to operating rooms and opening directly to the outside of the building, the opening being in such a position that gases and fire would not affect other parts of the hospital.

2. Static electricity: A common cause of explosions is static electricity which may be due to friction within, or friction external to, the machine, the latter being caused by persons entering or moving about the room. In the newest machines the manufacturers have guarded against accumulation of static electricity due to internal friction by humidifying the gases. Static electricity from external friction is prevented largely by proper grounding of the machine by numerous mechanical methods, none of which can be depended upon entirely. The simplest and safest method of dealing with this problem is to maintain in the operating room a humidity of the atmosphere of 65 or slightly higher. By the use of an inexpensive hydroscope the humidity of the operating room can be determined at any time. The source of the evaporation which maintains the humidity is arranged outside the operating room.

3. Electric sparks: The risk from electric sparks can be prevented by keeping all electrical connections tight and undisturbed in the presence of explosive gases. Switches should be of the type to prevent arcs, and the use of high-frequency machines of all kinds must be prohibited in the presence of an explosive anesthetic.

4. Open flames: Any open flame must be absolutely prohibited, even at considerable distance from the operating room, as air currents may carry an explosive mixture of gases some distance from its source.

5. Lighted cigars and cigarettes: A constant danger is the common habit of smoking which is practiced by surgeons and others near the operating room. This should never be tolerated.

Rules and regulations bearing on the elimination of all hazards in the operating room or wherever anesthetics are being administered should be clearly stated, and these regulations should be strictly adhered to by everyone who enters the operating rooms. It is advisable to have these regulations posted in conspicuous places and to have them easily readable, in order that everyone in or near the operating rooms may refrain from careless acts which might constitute a menace to himself or to others.

#### *Minimum Standard for Obstetrical Departments in Hospitals*

1. Accommodation: There shall be in all approved hospitals caring for obstetrical patients a properly organized and equipped department of obstetrics, providing exclusive and adequate accommodation for mothers and the newborn.

2. Isolation: Special accommodations and facilities shall be available for all cases of infection, elevated temperature, or any other condition inimical to the safety and welfare of obstetrical patients.

3. Facilities: Clinical laboratory, X-ray, and other facilities, under competent supervision, shall be provided for the diagnosis and treatment of obstetrical patients.

4. Administration: The administration of the obstetrical department shall be under the direction of a competent, registered nurse who has executive ability, who is specially trained in obstetrical nursing, and who shall have an adequate number of assistants and other personnel to carry on efficiently the work of the department.

5. Supervision: The obstetrical division of the medical staff shall be so organized as to exercise adequate control over the obstetrical work done in the hospital, such organization to include a chief or head of the department or service who shall be responsible for the general supervision of the professional activities of the department.



6. Records: Accurate and complete medical records complying with the required standard shall be provided for all patients admitted to the obstetrical department.

7. Consultations: Consultation with a physician qualified in obstetrical work shall be carried out and findings carefully recorded in all cases of major operative procedures, unless the physician in charge of the patient is a qualified obstetrician, or in an emergency when time does not permit.

8. Morbidity: All hospitals caring for obstetrical patients shall adopt a morbidity standard by which they can better control morbidities.

9. Conferences: A thorough review and analysis of the obstetrical work done in the hospital shall be made at least monthly, with particular consideration of the deaths, the unimproved cases, the morbidities, the infections, the complications, the results of treatment, and an analysis of clinical reports.

10. Training: Opportunity shall be afforded student nurses, in hospitals having a school of nursing, for adequate theoretical instruction and practical experience in prenatal work, observation of the patient in labor, delivery room technique, and postpartum care of the mother, as well as the proper nursing care of the newborn.

### *Obstetrical department*

The care of the obstetrical patient is of vital importance, and in order that it may be in accordance with modern obstetrical practice, approved hospitals are obligated to provide a service commensurate with certain fundamental requirements. The American College of Surgeons, in its effort to assist hospitals in the proper organization and management of their obstetrical departments, has formulated definite requirements which embody minimum standards that are adaptable to any hospital caring for obstetrical patients. Because these requirements are essential for the efficient care of maternity cases, they must be applied to all approved hospitals which maintain an obstetrical service.

While the following principles are applicable to an obstetrical department in any type of institution, it is recognized that it may be necessary for small hospitals—those of 50 beds or less—to make some modifications of these recommendations.

*Accommodation.*—In the larger hospitals the most desirable plan for an obstetrical department is a separate building designed for the exclusive accommodation of maternity patients and the newborn. In all general hospitals, excepting the very small ones, a strict segregation of patients can be arranged by the use of a wing or floor with separate nursing service, equipment, and supplies. The general accommodations should consist of private and semiprivate rooms, and small public wards. Two or more patients who occupy the same room can be separated by means of curtain screens or cubicles so that individualization of service and technique can be accomplished.

The general nursery is located preferably in a remote part of the obstetrical department where noise will not disturb the mothers, and as far from the delivery room as is practicable. This is not objectionable inasmuch as the two services are unrelated; furthermore, the many visitors who look at babies through the viewing window in the nursery would constitute a positive menace if permitted in the vicinity of the delivery room. The nursery unit should consist of an anteroom, a bathing and dressing room provided with individual trays, a heated linen closet, and a room in which individual cribs are so distributed that each baby may have at least 200 to 400 cubic feet of air space.

*Isolation.*—Adequate accommodation for isolation of the mother who develops fever or other signs of infection is of paramount importance. In the absence of a properly arranged isolation unit, infected patients should be taken outside the obstetrical ward to a room where there are no surgical or gynecological cases with open wounds that might cause cross infection. The best method is to remove infected obstetrical patients to a completely segregated section which has at least 1 bed for every unit of 25 obstetrical beds. A self-contained delivery room unit in the isolated or segregated area is most desirable. Infected babies should be removed immediately from the clean nursery to an isolation nursery equipped with cubicles. If the isolation nursery is strictly isolated, it can be located conveniently on the same floor as the general nursery and equipped as a self-contained unit with supplies for individual technique.

*Facilities.*—In addition to the clinical facilities—preparation, service, labor and delivery rooms, and nursery, which are integral units of the obstetrical department—the use of the adjunct facilities of the hospital for clinical laboratory and X-ray examinations and for special treatments is imperative for a complete service.



Frequent use of the clinical laboratory service is invaluable to good obstetrical practice. The X-ray likewise now plays an important role in determining the size and position of the fetus.

*Administration.*—The entire department should be under the supervision of a registered graduate nurse who has had special training and postgraduate experience of at least 6 months in an outstanding maternity hospital or an obstetrical department of a well-organized general hospital. She must possess not only a thorough knowledge of obstetrical nursing practice, but the qualifications of a good executive officer, that is, good supervisory, administrative, and teaching ability, tact, diplomacy, and a sympathetic understanding of human nature. In many hospitals in which more than one graduate nurse is necessary for supervisory purposes, head nurses are placed in charge of the three units—wards, nurseries, and delivery room suite, respectively.

Excepting student nurses in training, only qualified registered nurses should be engaged to provide the nursing service. A ratio of at least 1 graduate nurse to every 4 or 5 patients by day, and to 8 to 10 patients by night, is the minimum for post partum care, provided maids and attendants are available to do the nontechnical work. In the nursery during the morning 1 nurse is necessary for every 6 babies, while the ratio during the afternoon and night may be reduced to 1 nurse to every 12 babies. In the predelivery room there should be sufficient nurses so that no patient under analgesia or an anesthetic is ever left unattended. In the delivery room suite, in addition to the supervisor, at least 2 nurses for the care of each case are required. Granting that there is proper supervision, the allotment of student nurses should be at least one-third greater than that of graduate nurses. For day duty a ratio of 1 student nurse to every 3 or 4 patients, and for night duty 1 for every 5 or 6 patients, would be the minimum for post partum care.

*Supervision.*—Careful attention must be given to the supervision and control of the obstetrical work so that it will be kept up to acceptable standards. This can be assured only through proper organization of the medical staff in general and of the obstetrical division in particular. Medical staff organization in all except the smaller hospitals includes the attending and resident medical staffs. It is recognized that in most institutions obstetrics is practiced largely by general practitioners who represent a great proportion of the medical staff membership rather than by obstetrical specialists, and that in hospitals with an open medical staff the obstetrical department is usually open to a large courtesy staff. Therefore, in order to exercise proper control of this service, a well-organized medical staff and close medical supervision are especially important.

If maternal mortality is to be reduced, and if the hospital is to achieve the results which are possible through the application of present-day standards, a uniform system of medical staff organization and control must be strictly applied. The entire obstetrical service must be subject to active supervision by the chief of the service or the head of the department, or by his selected representatives, and possibly in smaller hospitals by an obstetrical committee. The duties of the supervising head or committee are to initiate the policies of the department, to establish and maintain a standard technique which may be revised when deemed necessary, to coordinate the service with other divisions of the hospital, to hold regular medical staff conferences for review and analysis of obstetrical work, and, if the hospital uses interns, to formulate a definite program for their education.

*Records.*—Complete obstetrical records are essential in every hospital. These records should embrace the following component parts:

1. Identification and registration data.
2. Personal and past history, with special reference to menstrual functions, pregnancies, miscarriages, labors, puerperia, and general health.
3. General physical examination with special examination to determine duration of pregnancy, position and condition of child, measurements, conditions of soft parts, or any abnormalities which might be present.
4. Consultations, laboratory, X-ray, and other special examinations.
5. Provisional diagnosis indicating position and presentation of the child.
6. Indications for operative procedure when carried out.
7. History of labor, including description of first, second, and third stages.
8. Final diagnosis.
9. Post partum progress.
10. Condition on discharge as revealed through examination.
11. Follow-up.

In addition, there should be a complete physical examination of the baby and record made of its progress while it is in the hospital. The newborn is just as much an individual in the hospital as is the adult patient. The infant occupies a bed, requires nursing care, and, with the growing custom of placing him under the pediatrician rather than the obstetrician, his medical record must, of necessity, be kept separate from that of the mother.

It will be readily noted from this outline that obstetrical records are just as essential as records in any other department of the hospital. The record is composed of three main parts: history of pregnancy, labor, and post-partum or puerperium. Occasionally hospitals have difficulty in securing the history of pregnancy for the first part of the record because of the contention that the hospital record begins with the report of labor and delivery. It must be emphasized that any obstetrical record which does not contain the history of pregnancy is incomplete and not acceptable.

There are various types of record forms available, many of which are outlined with numerous items. It is recommended that less detail be used in the preparation of the forms, as a more complete record pertaining definitely to each patient can be secured by following the outline for an obstetrical record rather than by confining the data to forms which are too stereotyped and limited.

*Consultations.*—Frequent consultations on all complications of pregnancy, and especially on major obstetrical operative procedures, are a most effective means of controlling the practice of obstetrics and of rendering the patient the best possible care. Consultations should not only be encouraged but should be required in all cases in which operative interference of a major nature is proposed, unless the physician in charge of the patient is a qualified obstetrician or in case of extreme emergency when time does not permit. Consultations also should be required in all cases scheduled for termination of pregnancy for any reasons whatsoever. The consultant should be a qualified obstetrician, that is, one of recognized standing in obstetrical work. The report of the consultant, consisting of findings and suggestions, becomes a part of the permanent medical record.

*Morbidity.*—It is exceedingly important that a careful study of morbidity be made in each hospital. Therefore, it is recommended that the medical staff adopt a morbidity standard as formulated and sponsored by The American Committee on Maternal Welfare:

"Temperature of 100.4° F. (38° C.); this temperature to occur on any 2 of the first 10 days post-partum, exclusive of the first 24 hours, and to be taken by mouth by a standard technique at least four times a day."

Through the use of such a standard an excellent index of the efficiency of both the medical and nursing services is provided and there is assured a greater tendency to stimulate action to investigate and regulate unfavorable conditions.

*Conferences.*—The clinical work of the department should be reviewed and analyzed, either in general conference or in departmental meeting, at least once each month. In larger hospitals the department will need to meet weekly or semimonthly to complete the proper analysis of the work. Consideration should be given to all work which does not meet the required standard and special study should be made of all mortalities and morbidities. Studies of different groups of diseases or conditions over a period of years would be advantageous in promoting a thorough study and comparison of end results.

*Training.*—A period of at least 4 months in the obstetrical department is necessary for student nurses to receive adequate training in the theoretical and practical work of obstetrics. During this period the time should be divided so as to provide experience in the wards, delivery room, and nursery. Supervised demonstrations and practical instruction should be arranged and a comprehensive course of lectures in obstetrics should be given as part of the education of the student nurse. The supervisor and her assistants must be well trained teachers in this field in order that the pupil nurse may be properly taught.

Hospitals complying with the minimum requirements herein described will be rewarded by a service which will assure safe and efficient maternal care and which will tend to reduce maternal morbidity and mortality.

#### *Minimum Standard for Eye, Ear, Nose, and Throat Departments in Hospitals*

1. Accommodation: Eye, ear, nose, and throat patients in general hospitals shall be accommodated in a section of the hospital set aside especially for that purpose; when this is not possible, a portion of the general ward shall be assigned to these specialties.



2. Treatment: Special operating, examining, and treatment rooms shall be arranged in the eye, ear, nose, and throat section; if this is not possible, a special operating room or rooms of the general operating suite shall be assigned for this purpose.

3. Facilities: Diagnostic and therapeutic facilities shall be provided through the general services, including such additional features as are required.

4. Personnel: Adequate professional and other personnel with the essential special training and under proper supervision shall be provided for the eye, ear, nose, and throat department.

5. Medical staff: The medical staff shall comprise exclusive specialists in diseases of the eye, ear, nose, and throat, an organized group of the general staff, subject to the medical staff rules and regulations.

6. Conferences: The medical staff of the department shall hold regular conferences for the thorough review and analysis of the clinical work.

7. Records: Accurate and complete medical records, filed in an accessible manner, shall be provided for all cases treated.

8. Training: Interns and nurses, whenever practicable and possible, shall be given theoretical instruction and practical experience in the care of eye, ear, nose, and throat patients.

### *Eye, ear, nose, and throat department*

The diagnosis and treatment of diseases of the eye, ear, nose, and throat require specialized personnel and procedures, and at times special facilities are necessary for the examination of systemic functions. Since the general hospital has the facilities for such study, it is distinctly advantageous to establish an eye, ear, nose, and throat department in such a hospital. On the basis of this premise, the following statement of essential principles has been formulated for the guidance of hospitals and medical staffs in the organization and administration of these special departments. A detailed explanation of the requirements is found in the Hospital Standardization Report, Bulletin of the American College of Surgeons, October 1936, pages 36 to 40. A brief summary of this report follows:

*Accommodation.*—Most hospitals, except those in the smaller group, can reserve a section for eye, ear, nose, and throat patients. The accommodation usually required is seven-fiftieths of the total bed capacity, and should, if possible, be grouped in one section of the hospital. Small wards are preferable, one each for men, women, and children, with private rooms in adjoining or nearby sections. When it is not possible to assign a special section, a definite group of beds in the general ward can be reserved for these services.

In addition to the general arrangement suitable for any surgical patient, the following special facilities are needed:

1. A proportionate number of beds with removable head to facilitate certain treatments, located where strong light can be excluded.

2. Electric lights placed at the head of each bed for the use of headlights and other appliances, and a portable light with opalescent bulb for oblique illumination and for use with a head mirror.

3. Dressing trays containing special supplies for the treatment of eye, ear, nose, and throat patients.

*Treatment.*—In addition to the rooms and equipment commonly found in the general operating suite, a special unit for treatment of eye, ear, nose, and throat cases includes an examining and treatment room, a dark room, and a refraction room. These rooms, whether separate or in the main section, are under the general operating room administration. When a special suite of this type is not practicable, specified rooms may be set apart in the general operating room unit.

*Facilities.*—The central clinical laboratory in a general hospital can usually provide all the laboratory service required by the eye, ear, nose, and throat department. Any other facilities for special examinations may be added as required, duplication of equipment thus being avoided. As a minimum, the laboratory should provide for routine urinalyses for all patients, for bacteriological examination of smears and cultures, and for a pathological report on all tissues removed at operation.

A well-equipped X-ray department in a general hospital is usually sufficient for the eye, ear, nose, and throat service. A portable X-ray unit is often a great convenience in the operating room or ward. Apparatus for localizing foreign bodies in the eye is the principal special X-ray equipment needed.

*Personnel.*—The eye, ear, nose, and throat department requires the competent supervision of a graduate nurse, well trained in this special work. As in the other departments, she must possess executive ability in order to manage the department efficiently.



A high standard of nursing service is especially important in this department, since the results of the work in these specialties are so often dependent upon proper nursing care. While the supervision of the wards and operating rooms is placed under the general administration of the hospital and surgical department, the nurses actually assigned to the care of patients must be especially trained to carry out the technique and to recognize untoward signs and symptoms. If student nurses are on duty, only seniors who have had basic training on the general surgical service should be assigned to this department, and no nurse should be allowed to apply dressings or to carry out special procedures unless she has been properly trained and appreciates the delicacy of the work.

*Medical staff.*—Members of the medical staff should be exclusive specialists in ophthalmology, rhinology, and otolaryngology. They are selected according to the plan approved for the appointment of the general medical staff. The members of this group should be definitely organized as a department or as a division of the general medical staff and should be represented on the executive committee of the medical staff. A president and secretary should be elected and at least two committees are required, namely:

1. Efficiency committee, to study equipment, technique, and procedures, and to formulate recommendations for changes and improvements in the service.
2. Medical records and program committee, to review and appraise the medical records and to prepare programs for the regular meeting of the section in which the clinical work is reviewed and analyzed.

*Conferences.*—The members of the eye, ear, nose, and throat group may elect to have their own departmental conference for the review and analysis of the clinical work, but they should also attend the conference of the general medical staff. Through the meetings of this group, the work of the eye, ear, nose, and throat division is maintained on a high plane of efficiency and the administration of the hospital is kept advised regarding professional matters.

*Records.*—The medical records of patients in the eye, ear, nose, and throat department should be just as complete as any other records in the hospital, and should follow the outline of component parts of a general medical record as described in *article IV* of the Minimum Standard for Hospitals in this Manual (pp. 27 to 31).

It is true that special forms are used for eye, ear, nose, and throat examinations, but the principles involved are the same. The history and physical examination should be sufficient to prove that the diagnosis is justified and that the patient is physically fit to undergo operation or other treatment. Therefore, this means that all the preliminary examinations and provisional or preoperative diagnoses are to be recorded before treatment is started. Following the report of treatment and progress, the condition on discharge is described and a follow-up report is instituted, which is especially important. The completed chart is promptly filed and indexed and is thus made readily available for future reference and review.

*Training.*—If there is a well-organized service, nurses and interns should be offered theoretical and practical instruction in this department. The training is in no way intended to make them specialists in their particular fields, but merely provides an opportunity to secure basic knowledge incident to general medical and nursing practices. Unless the assignment is for 2 years or more, the resident cannot expect to acquire much experience in operative technique. Likewise the student nurse in the average period of training offered can be expected to learn only the basic principles of nursing care. Whenever conditions are suitable, an opportunity should be offered for postgraduate study.

#### *Minimum Standard for Treatment of Fractures and Other Traumas in Hospitals*

1. Hospitals: Hospitals admitting cases of injury for treatment shall be required to meet the minimum standard for hospitals of the American College of Surgeons and to have complied with the essential requirements for approval which implies that they shall have available adequate diagnostic and therapeutic facilities.

2. Equipment: All general hospitals shall be equipped for care of fractures and other injuries, the minimum equipment for transportation, emergency treatment, and after-care being the following or its equivalent:

Murray-Jones arm splint; Keller-Blake hinged half-ring splint, with traction strap, slings, and buckle straps; Hodgen splints; coaptation splints, assorted sizes; Cabot wire splints; wooden splints, assorted sizes; plaster of paris bandage; Bradford frame; overhead frame for suspension; fracture table; fracture bed; and portable X-ray.

In addition, the hospital shall provide an accident department with supplies available at all times for emergency use.

3. Supervision: It is highly desirable that one individual surgeon competent in the field of fractures shall be responsible for supervising the care of fracture cases. Organization of the services for the care of all injuries shall include specialists competent to treat other specific injuries. A committee may be appointed for that purpose.

4. Records: Special record forms shall be used for fracture cases. Adequate medical records shall be maintained for all cases of other injuries.

5. Follow-up: A close follow-up shall be maintained on all cases of injury for such time as is necessary to establish an accurate knowledge of end results.

#### *Treatment of fractures and other traumas*

Through its committee on fractures and other traumas, the American College of Surgeons has accomplished much of value in improving the hospital care of patients having fractures and other injuries. Extensive data were secured as to how these cases were being cared for and what was needed to improve these services. Because of the increasing importance of the care of the injured and the responsibility placed on hospitals to meet this requirement, the American College of Surgeons, after thorough investigation and analysis of the valuable information collected, formulated a minimum standard for the transportation, emergency treatment, and after-care of fractures. A minimum standard for traumatic surgery in hospitals has also been formulated, but it now seems feasible to combine these minimum standards.

*Equipment.*—For the more efficient and safe treatment of fractures and other traumatic cases, it is essential that hospitals have available, ready for use, a supply of splints as listed above. This is best accomplished by arranging a splint room in a convenient location. Obviously the clinical laboratory, the X-ray department, and the other departments of the hospital will have the necessary equipment to provide such other services to the patient as are required in an approved hospital. A portable X-ray machine is always a great advantage, inasmuch as it allows observations to be made without moving the patient.

In addition, each hospital should have a well-organized emergency or accident department with personnel and supplies ready at all times for the efficient care of the injured patient.

Immediate fixation of fractures of long bones, at the site of accident and before the patient is moved, is of extreme importance in order to avoid further injuries and complications. For this reason ambulances should be equipped with Thomas-type splints for upper and lower extremities, and with gauze and bandages needed for applying them, together with other necessary first-aid supplies. The ambulance surgeons and ambulance attendants should be well trained in first aid and in the application of these splints.<sup>1</sup>

*Supervision.*—All surgeons are not equally capable of treating fractures; their training, experience, and personal interest in the subject differ widely. Having one individual surgeon responsible for supervision of the care of fractures in each hospital not only assures the hospital and the patients of uniform standards of excellence in treatment but also places at the disposal of all members of the medical staff the experience of the supervising fracture surgeon. The care of fracture cases by individual surgeons is in no wise interfered with, and the uniformity of records with which end results may be compared is greatly facilitated. The supervising surgeon will be given an opportunity for constant study of fractures and their treatment. In this manner, the hospital will have a surgeon who may be regarded as an authority on the subject. National organizations interested in the treatment of injuries will supply him with their findings, and he will be able to furnish them with data on which further conclusions may be based.

Organization of the services for the treatment of fractures and other traumas shall provide that other competent specialists be constantly available to supervise the treatment of other specific injuries. It is equally important that head injuries be treated by those whose training and interests make them especially competent in this field. Likewise injuries to the chest, to the abdominal viscera, to the urogenital tract, and to the peripheral nervous and circulatory systems should all be handled by well-qualified specialists.

<sup>1</sup> Methods for the application of traction are described and illustrated in *An Outline of the Treatment of Fractures*, prepared by the committee on fractures and other traumas, published by the American College of Surgeons; also in an article by Dr. Robert H. Kennedy, of the committee on fractures and other traumas, bulletin, American College of Surgeons, 1933, xvii, No. 2, p. 21, reprints of which are available.



In this connection the management of the hospital and medical staff, particularly in "open hospitals" with large courtesy staffs, should require consultation on all major injury cases.

*Records.*—The attention of hospitals is directed to the advantages of using the record form for fractures as recommended by the American College of Surgeons (addendum VII, pp. 108–109). This will provide the committee on fractures and other traumas with more uniform data for study and will thereby render a broader service. Records of all cases of injury shall include identification data, the immediate record of the injury, detailed description of physical findings, records of essential diagnostic X-ray and clinical laboratory examinations, adequate record of treatment, a record of prognosis with estimated period of disability progress notes, description of condition on discharge, and a record of end results.

The essentials of well-organized services for the care of fractures and other traumas may be summarized as follows:

1. An efficient, promptly responding, well-equipped ambulance service with competent personnel in charge.

2. A readily accessible casualty department to afford quick transference of patient from ambulance to bed or operating table.

3. A well-equipped emergency operating room with supplies always ready for use.

4. A small recovery ward where the patient can be sent after emergency treatment.

5. An efficient hospital personnel always on duty or on call which should include at least a competent physician, a nurse, and an attendant or orderly.

6. Supervision of the treatment of fracture cases by a well-qualified surgeon, and supervision of the care of other injuries by those who are competent in their respective fields.

7. Adequate diagnostic and therapeutic facilities under competent medical supervision.

8. A complete medical record of all patients treated which includes particularly an immediate record of injury and a detailed description of physical findings, treatment, and end results.

#### *Minimum Standard for Cancer Clinics in Hospitals*

1. *Organization:* There shall be a definite organization of the service, and it shall include an executive officer and representatives of all the departments of the hospital concerned in the diagnosis and treatment of cancer. The services of a secretary and of a social service worker shall be available for the purposes of the clinic.

2. *Conferences:* As an essential feature of the service there shall be regular conferences or consultations at which the diagnosis and treatment of the individual cases are discussed by all members of the clinic who are concerned with the case.

3. *Patients:* Reference to the cancer clinic of all patients in whom the diagnosis or treatment of cancer is to be considered shall be either voluntary or obligatory in accordance with the vote of the medical staff or of the governing board of the hospital.

4. *Equipment:* In addition to the diagnostic and therapeutic surgical equipment which is required in every approved general hospital there shall be available an apparatus for X-ray therapy of an effectiveness which is generally agreed upon as adequate, and an amount of radium sufficient to insure effective treatment.

5. *Records:* In addition to the records which are required in every approved general hospital, there shall be additional records of: (a) Details of the history and of the examination for cancer in different regions of the body, such as are indicated on the form records which are recommended by the cancer committee, American College of Surgeons, (b) details of the treatment by radium or X-ray as indicated on the form records which are recommended by the cancer committee, American College of Surgeons, (c) periodic examinations at intervals for a period of at least 5 years following treatment.

6. *Treatment:* The treatment of cancer patients shall be entrusted to the members of the staff of the cancer clinic except in cases in which adequate treatment in accordance with the collective recommendation of the staff of the cancer clinic can be procured otherwise.



*Cancer clinics*

The demands created by modern methods in the pathology, diagnosis, treatment and follow-up of malignant disease constitute one of the most complex problems in any field of medical effort. Only in recent years has there been any significant movement toward a specialized service for the cancer patient. Such a service demands specialized effort by a group that is representative of the several specialties which are most concerned with the various phases of cancer diagnosis and management, rather than by an individual. This thesis is one of the basic principles incorporated in the cancer clinic program of the American College of Surgeons.

The consensus of authoritative contemporary opinion in the cancer field is that further expansion of group effort in cancer services in general hospitals, together with continuous professional and lay education, constitute the only immediate means of reducing cancer mortality and morbidity. Unfortunately, it is still not uncommon for the cancer patient to receive inaccurate diagnosis, and ill-advised or inadequate treatment, with little or no attempt at follow-up. The college aims to secure the eventual distribution of cancer clinics throughout the country in such numbers and in such strategic locations as to make their services available to the greatest possible number of patients.

A vitally important step preliminary to the organization of a cancer clinic is to obtain the support of members of the medical staff of the hospital. They must take cognizance of the fact that only by the concentration of cases in a special service can the management of cancer cases be improved. The cancer clinic should be recognized as an integral part of the hospital organization, and as much an entity as are the departments of medicine and surgery, although representatives of these latter departments constitute an integral part of the cancer clinic staff.

A cancer service will attain greater efficiency when directed by a permanently designated personnel, selected from the various departments for their previous training in oncology, or their ability in some special field as its relates to malignant disease and their willingness to devote special time and effort to this endeavor. The key members of the cancer clinic staff are the pathologist, radiologist, general surgeon, and internist. Also essential is the availability of the services of representatives of the surgical specialties—gynecology, urology, otorhinolaryngology, orthopedics, as well as dermatology and such other special departments of the hospital as may be concerned with the diagnosis and treatment of cancer. The services of an oral surgeon are frequently of great value.

This does not imply that the general staff is to be excluded from interest in the work of the cancer clinic. On the contrary, their participation and attendance, especially at formal conferences, is part of the whole program. It is also essential that department representatives on service participate in presenting and discussing cases from their respective departments, and it is equally advantageous for physicians to take a similar responsibility when they refer patients to the clinic.

Secretarial assistance is invaluable; the presence of a secretary at each clinic session enables the staff of the clinic to dictate adequate details of history, physical examination, discussion, recommendations, and follow-up. Social service work forms an integral part of a cancer clinic; through it is obtained efficient, long-range follow-up of cancer patients. With inadequate knowledge of end results it becomes impossible to judge the merits of therapeutic measures. Except in larger clinics, both secretarial and social service aid are required only on a part time basis.<sup>1</sup>

*Minimum Standard for Physical-Therapy Departments in Hospitals*

1. Organization: Hospitals which maintain a physical-therapy service shall have a well-organized department with adequate, trained personnel under competent medical supervision.

2. Planning: The physical therapy department shall be properly planned and equipped in accordance with present day standards.

3. Records: A comprehensive system of records shall be available in the department and filed in an accessible manner.

4. Procedure: A definite procedure shall be established for the reception, treatment, and discharge of the patient.

<sup>1</sup> Complete details for establishing cancer clinics will be found in the pamphlet *Organization and Conduct of Cancer Clinics in General Hospitals*, reprinted from Bulletin, American College of Surgeons, April 1939.

5. **Conferences:** Periodic analyses of the work of the department shall be made to determine the results.

### *Physical therapy*

Physical therapy has proved so advantageous in such a wide variety of cases, particularly rehabilitation of the injured, fractures and other traumas, diseases of metabolism, nervous disorders, and many other diseases or conditions, that almost every general hospital would find considerable use for a well planned and organized department. The forms of treatment offered by this branch of medical science in properly selected cases hastens convalescence, shortens the patient's stay in the hospital, and improves end results. Hospitals seeking guidance in the organization and management of a modern physical therapy department are advised to observe the requirements as stated and described herein.

**Organization.**—If the department is to achieve the desired results, it is imperative that the director be a medical graduate specially trained in physical therapy. Without a medical education and special training in this branch of work he is not capable of judging the type of treatment best suited to the patient's condition or of outlining a prescribed course that will aid in rehabilitation. Physical therapy is of value only when properly administered; it may do harm if given by a person not having an adequate knowledge of anatomy and physiology.

**Planning.**—In planning the physical therapy department ample space should be provided for treatment and dressing rooms. Inasmuch as most of the physical therapy equipment is portable, it is desirable to have the rooms so planned as to be convertible for different types of apparatus. It is necessary that all rooms have sufficient light and air, and that those in which electrical equipment is used should be floored with rubber tile. All apparatus should be as shockproof as possible and meet the approval of the council on physical therapy of the American Medical Association.

It is important that well trained technicians be available to assist the director in the treatment of these cases. The status of the physical therapy technician is being improved through registration with the American Registry of Physical Therapy Technicians as sponsored by the American Congress of Physical Therapy. The educational standard for technicians or aids should be that established by the American Physical Therapy Association.

**Records.**—The relative newness of scientifically practiced physical therapy makes accurate records of this specialty extremely valuable. These should include a brief summary of the clinical history, with provisional diagnosis, description of treatment as to type and quantity, report of progress while under treatment, and a detailed description of the condition of the patient on discharge.

**Procedure.**—Physical therapy has so often been practiced by those who were unqualified that for a long time it was in disrepute. It is only since noted physicians have turned their attention to its scientific administration that its true worth has become widely recognized. Proved methods of treatment shown by authorities to be sound are best adapted to the hospital which is about to open a physical therapy department. A regular, timed schedule of treatment should be required. The hospital must insist that each patient be thoroughly examined and the diagnosis carefully confirmed before treatment is administered. Much has been done by the Council on Physical Therapy of the American Medical Association to regulate and stabilize the various forms of physical therapy.

**Conferences.**—Notwithstanding all that has been said of the value of physical therapy, the limitations of the various forms of treatment must be fully recognized. It is only through proper evaluation of the improvement obtained from this form of therapy and through careful study of end results that the real worth of this branch of medicine can be established. The future success in the scientific development and use of physical therapy depends upon the careful observation of end results.

### *Occupational therapy*

Occupational therapy has made steady progress in recent years, not only in connection with the rehabilitation of chronic cases, but also in the care of acutely ill patients who are subject to protracted convalescence.

The space required for the department will vary from a minimum of 300 square feet to an entire floor of the hospital, or even to a whole building, de-



pending principally upon the size of the institution served, the number and type of patients suitable for occupational therapy, and the extent of the facilities provided for treatment. The most common crafts, all or part of which may be employed, offer a wide range of activity, and since the equipment will depend entirely on the crafts utilized, it should be selected by the therapist in charge of the department.

In order that occupational therapy may be properly used, the department must be directed by a trained therapist and the treatment should always be under the supervision of the attending physician. The staff of assistants should be adequate to supervise the work of the patients.

Reports are often made verbally to the physician, but a better system is to make written reports in duplicate, one copy to remain in the department, the other to be attached to the patient's chart. The work is too varied to warrant the use of special record forms, although certain data should be recorded for all patients, namely, patient's name, location in hospital, craft used, its extent, and reactions of the patient. The records should be filed numerically and indexed for the patient and the craft used. A review of results attested by the records will serve as an invaluable guide in the further development of the occupational-therapy service.

### *Oxygen therapy*

The value of oxygen therapy has been proved. The recent advances in this field are due not only to the improvement in the equipment and technique, but to the increase in knowledge and experience, which showed that failures were largely due to the administration of the oxygen too late in the course of the disease, to the withdrawal of the oxygen too soon, or to faulty dosage and administration.

Today, oxygen is administered before the patient has developed serious anoxemia and is continued until well after anoxemia is fully controlled: at the same time the air is properly conditioned for temperature, humidity, and carbon dioxide content.

Three methods of administration are enumerated below:

1. Intranasal catheter, the use of which requires the simplest equipment and is the least expensive.
2. Oxygen tent, a portable equipment which has been perfected so that a definite percentage of oxygen can be maintained for a long period of time under proper conditions of temperature, of moisture, and of carbon dioxide content.
3. Oxygen room, where a constant supply of oxygen of any desired percentage can be maintained under proper conditions of temperature, moisture, and carbon dioxide content for an indefinite period without variation in conditions.

The choice of the above methods depends upon which one could be used to the greatest advantage in the presence of controlling factors in each institution, one of which may be the cost of installation and maintenance.

Oxygen therapy is controlled by the department of medicine. As in other branches of therapeutics, the service must be under the supervision of a member of the medical staff who has knowledge and experience concerning the mechanics of the apparatus in use, as well as of the scientific principles of therapy. He should have a sufficient number of nurses, especially trained in the detail of technique, to assist him.

### *Minimum standard for out-patient departments in hospitals*

1. Administration: Medical service for ambulatory patients shall be organized as a definite out-patient department of the hospital under the supervision and direction of a qualified administrative official of the hospital.
2. Facilities: Adequate and properly arranged accommodations and facilities shall be provided for the physical comfort and convenience of patients, medical staff, and personnel, in addition to the equipment necessary for efficient, professional care of patients.
3. Personnel: The out-patient department shall be provided with sufficient personnel—physicians, nurses, social workers, and clerical assistants—to assure proper care of the patient.
4. Qualifications: The medical staff of the out-patient department shall meet the same requirements and qualifications which apply to the attending medical



staff of the hospital, the special demands of out-patient work to be considered in relation to the individual appointments.

5. Organization: The medical staff of the out-patient department shall be organized as a division of the attending medical staff of the institution, and whenever possible the members shall be allowed to follow their patients who are transferred from the out-patient to the in-patient department.

6. Conferences: The medical staff of the out-patient department shall hold regular conferences for the review and analysis of the clinical work of that department; in addition, properly selected cases shall be presented at the general clinical conferences.

7. Records: Accurate and complete medical records, including social and scientific data, shall be written on all patients, and shall be filed and cross-indexed in such a manner as to be readily available at any time for reference, restudy, and statistical and clinical research.

8. Correlation: The out-patient medical records shall be correlated with those of the hospital by a transfer of records or a transfer of clinical summaries at the time a patient passes from hospital to clinic, or vice versa; or more satisfactorily, by a central system whereby the entire history is assembled and is available to either division of the hospital in which the patient may be receiving treatment.

9. Services: Clinical laboratory, X-ray, and other diagnostic and therapeutic services of the hospital shall be available for out-patients whenever such services are required.

10. Number: Patients accepted for care in the out-patient department shall be limited to the number that can be cared for by the medical staff on duty, and accommodated by the space and equipment available.

#### *Out-patient Department*

The approved hospital with its numerous diagnostic and therapeutic facilities is ideally suited for the efficient conduct of an out-patient department as one of its integral units on a par with other departments. Through this department it is possible to provide effective treatment for many serious diseases while they are still in a curable stage and while the patient is ambulant. Hence, the hospital having an out-patient department is an important agent in the prevention of disease and the prolongation of human life. There is opportunity to correlate social service with medical service, and thereby to provide a better connecting link between the hospital and the community. Moreover, the out-patient department serves as a valuable field of research and educates the medical student in causes and methods of treating disease. Worthy of consideration by all institutions in the organization and management of an out-patient department is the minimum standard which has been developed after extensive study and investigation, the application of which has proved practical and advantageous in a large number of hospitals of the United States and Canada.

A common fault of hospital out-patient departments is that they sometimes operate as separate institutions without relation to the hospital as a whole. This plan entails a heavy financial burden, since it means in many instances unnecessary duplication of personnel and equipment. There is the likelihood, also, that out-patients will be deprived of some of the scientific resources which are available to in-patients. The better method is to locate the out-patient clinic in the same physical plant with the other departments and in close proximity to the clinical laboratory, X-ray, and other diagnostic and treatment facilities. If the condition of the patient becomes acute or presents difficulty in diagnosis, all the facilities of the hospital should be at the disposal of the medical staff to insure the efficient care of the patient.

The out-patient department is not a place in which the inexperienced physician or recent medical graduate should be given full charge. More experience is needed for the diagnosis of pathological conditions in their early stages than when they are fully advanced; hence, it is necessary that the very best medical talent obtainable be provided for the out-patient specialties and that young graduates work under the most skilled supervision. The medical staff should be selected in accordance with the requirements of clause II of the Minimum Standard for Hospitals, and should be a division of the regular staff of the hospital through which proper supervision is exercised.

The number and variety of clinics in the out-patient department of any hospital depend on the degree of specialization existing among the medical staff,

the physical facilities, and community needs. The following is a fairly complete range of clinics found in out-patient departments of leading institutions:

Medicine	Psychiatry
Surgery	Tuberculosis
Obstetrics	Venereal diseases
Prenatal	Cancer
Postnatal	Cardiac diseases
Gynecology	Gastrointestinal diseases
Ophthalmology	Metabolism diseases
Otorhinolaryngology	Diseases of nutrition
Urology	Allergy
Orthopedics	Physical therapy
Pediatrics	X-ray therapy
Dermatology	Well-baby clinic
Neurology	Accident, emergency.
Dentistry	

Before a hospital establishes a clinic there must be assurance that a need for such service actually exists, and that the hospital is able to provide the necessary facilities and personnel, including the required medical, nursing, technical, and clerical staffs.

It is absolutely imperative that out-patient departments have one or more medical social workers. Each applicant for treatment requires a complete social case study which should be obtained by persons specially trained for this work. The medical social worker can also do a great deal to prevent what is known as "clinic abuse."

The nursing staff and the nonprofessional personnel of the out-patient department must have as high qualifications as those in other divisions of the institution. A sufficient staff of skilled assistants should be provided in order that the medical staff may be free from administrative duties and routine tasks.

Medical records in the out-patient department, just as for ward cases, should give an accurate picture of the patient's condition and should contain all the facts bearing on the case. The record system should be so arranged that a patient's record can be removed at any time to accompany him if he is transferred to other departments of the hospital. In this respect the central system of medical records is most practical. This will prevent duplication of laboratory examinations, history taking, and treatment, and will serve to coordinate all forces of the hospital in the care of the patient. Similarly, when the patient is able to leave the ward, his medical record should be sent to the out-patient department as an aid in follow-up. In this way the scientific services of the hospital are correlated.

### *Follow-up*

The American College of Surgeons strongly advocates a follow-up as far as practicable and possible on all cases discharged from the hospital. Arrangements may be made whereby the patient returns to the office of the physician; he may be transferred to the out-patient department; he may be seen by another physician to whom he is referred; or he may be visited by the medical social worker.

To insure a successful follow-up system a definite routine must be established, so that patients will come when they are expected, and that absentees may be investigated. In more serious cases follow-up should be prompt and should always be made by personal visits. A personal interview between the patient and a professional worker, and reexamination by the physician will produce far better results than dependence upon questionnaires and written communications. It is particularly desirable that a close follow-up be maintained on all fracture cases for a time sufficiently long to establish an accurate knowledge of end results. Likewise, it is most desirable that every patient who is operated upon for cancer should be followed up diligently for the remainder of the patient's life. The cancer committee of the American College of Surgeons advises that the patient should be examined every 2 months for the first 6 months following operation, every 6 months from then on for 3 years, and after that once a year for the remainder of his life. Similar follow-up could well be extended to other cases of prolonged, recurring illnesses, such as diseases of the heart and kidneys, tuberculosis, arteriosclerosis, diabetes, chronic arthritis, and other diseases.

Through bringing the patient back for reexamination, through the collection of additional information from time to time, and through the building up of social adjustments, much can be done not only to stabilize end results, but to advance



the knowledge of these diseases as affecting diagnosis and treatment, as well as to stimulate better preventive measures.

### *Autopsies*

The incidence of autopsies in any hospital is a good criterion of its scientific progress in the study of the disease. Every approved hospital should aim to secure as many autopsies as possible, and at least for 15 to 20 percent of the deaths. Many hospitals secure a much greater percentage than that, and the number is as high as 80 to 90 percent in a few institutions.

Continuous efforts to secure autopsies in hospitals are well worth while when the benefits accruing to medical science and humanity are considered. Not only do the physician, the medical student, the research worker, and others allied with the practice of medicine gain from such knowledge, but great benefit also devolves upon the family of the deceased and future patients from the disclosure of obscure findings not otherwise discernible. These findings may be of vital importance to the future health of the members of the family, in the settling of compensation insurance, or in other matters of material concern. The future patient benefits through the increased knowledge of his physician who is assisted in studying the changes in body tissues produced by disease, and is given a fuller understanding of symptoms as related to pathology and of appropriate methods of treatment.

It may be said that the autopsy acts as a check on clinical diagnosis, stimulates greater accuracy of clinical observations, serves to detect obscure diseases, and frequently throws light on medicolegal problems. It is over a source of new knowledge in that it provides material for medical staff conferences and for graduate and undergraduate medical education. Definite organization and procedure are essential in securing satisfactory incidence of autopsies in hospitals. The following underlying principles should be observed in every hospital in order that the greatest benefits may accrue from autopsies:

1. The whole-hearted interest and cooperation of all groups connected with the care of the patient—the governing board, the medical staff, the superintendent or administrator, and the personnel.
2. The adoption of a definite routine procedure through which proper contacts can be made in securing the autopsy.
3. A competent pathologist and adequate physical facilities and accommodations.
4. Notification to members of the staff of each autopsy to be performed and invitation to be present.
5. The findings from autopsies made available for study at the medical staff conference or properly conducted clinicopathological conference.

The study of findings from the autopsy is of vital importance if the interest of the medical staff is to be sustained. This is best done through conducting a proper clinicopathological conference such as is now carried on in many institutions, where the autopsy findings, gross and microscopic, are demonstrated and correlated with the clinical history. In this way errors and omissions in diagnoses may be discovered, a better appraisal of the clinical work is assured, and advancement is made in the scientific knowledge of the practicing physician, the resident, the intern, and the medical student. In some instances, nurses in training are given the advantage of seeing the pathological findings so as to assist them in the study of disease which is helpful in furthering their nursing education.

Inasmuch as autopsies are so essential in advancing the knowledge of disease, it is urged that the utmost cooperation exist between the managements and medical staffs of hospitals in increasing the percentage of autopsies. In this it is also essential to have the interest and good will of the undertakers and the public.

### *Consultations*

Frequently of consultations in hospital practice is a valuable index to the quality of the scientific work. It is estimated that as a general average 15 to 20 percent of patients would benefit by proper consultation. Some hospitals have a ruling that consultations must be held on all major surgical operations or major operative obstetrics—a commendable rule if it is applied conscientiously.

A consultation to be properly conducted embraces the following procedures:

1. A formal, signed request for consultation by the attending physician on a prescribed form.
2. Adequate examination and study of the patient's condition with correlation of laboratory and other findings to assure an accurate opinion.



3. A report by the consultant of his findings and recommendations, followed by a discussion of same with the attending physician.

It is expected that the consultant will maintain ethical relations toward the attending physician by not seeing or discussing his findings with the patient without the attending physician being present or without his consent. Many so-called informal consultations are held, but these should not be considered as consultations because of failure to include a thorough examination of the patient. It should be remembered that accuracy of opinion and soundness of judgment can be assured only through study of the patient's history and careful examination.

There are two types of consultations: first, the private consultation, when the physician or patient requests it, in which case the physician may collect his fee; second, the house consultation resulting from a regulation of the hospital requiring consultation in certain types of cases, when the consultant gives his service gratis. These two types of consultations should not be confused.

The consultation is an advantage to all parties concerned:

1. The patient is assured a more accurate diagnosis and better treatment.
2. The requesting physician is supported in the conduct of the case and responsibility is shared.
3. The consultant's knowledge and experience are broadened by this contact.
4. The hospital is better protected from inefficient work, for the consultation is a deterrent to incorrect procedures.

The choice of consultant must always be carefully guarded and, so far as is possible and practicable, confined to outstanding specialists. Frequently the clinical pathologist and radiologist can advantageously be called for consultation at the bedside or in the operating room.

#### MINIMUM STANDARD FOR PHARMACIES IN HOSPITALS

1. Organization: The hospital shall have pharmaceutical service: (a) the full or part time of a graduate registered pharmacist, or (b) pharmaceutical service from an approved nearby pharmacy.

2. Committee: The hospital shall appoint a pharmacy committee, which shall meet at regular intervals. The members of the committee shall be chosen from the several divisions of the medical staff. The pharmacist shall be a member of the committee and shall serve as its secretary. He shall keep a transcript of proceedings, and forward a copy to the proper governing board of the hospital.

The purposes of the pharmacy committee shall be: (a) to determine the policy of operation of the pharmacy, and to deal with such other matters of a pharmaceutical nature as may from time to time arise, (b) to add to and delete from the drugs used, (c) to supervise the purchase and issuance of drugs, chemicals, pharmaceutical preparations, biologicals, and professional supplies within the hospital.

3. Library: The hospital shall maintain an adequate pharmaceutical reference library: (a) United States Pharmacopeia, National Formulary, New and Non-official Remedies, United States Dispensatory, reference works on inorganic, and quantitative chemistry, pharmacology and toxicology, bacteriology, and a medical dictionary, (b) the Journal of the American Medical Association, the Journal of the American Pharmaceutical Association, the Year Book of the American Pharmaceutical Association, the federal regulations relative to the dispensing of alcohol and narcotics, and a copy of the state and municipal pharmacy laws and sanitary code.

4. Standards: The hospital shall use drugs, chemicals, and pharmaceutical preparations of at least United States Pharmacopeia, National Formulary, and New and Nonofficial Remedies quality in the treatment of patients.

5. Supervision: The pharmacist shall have immediate supervision over: (a) the routine preparation of injectible medication and sterilization of all preparations he himself prepares, (b) the routine manufacture of pharmaceuticals, (c) the dispensing of drugs, chemicals, and pharmaceutical preparations, (d) the filling and labeling of all drug containers issued to nursing units from which medication is to be administered, (e) a semimonthly inspection of all pharmaceutical supplies on nursing units, (f) the maintenance of an approved stock of antidotes in the emergency suite, (g) the dispensing of all narcotic drugs and a perpetual inventory of them, (h) specifications for purchase of all drugs, chemicals, and pharmaceutical preparations used in the treatment of patients, (i)

specifications for purchase and storage of biologicals and all operations wherein a special knowledge of pharmacy, including a ready knowledge of weights and measures in all systems, is necessary.

### *Pharmacy*

The pharmacy is one of the most extensively used therapeutic facilities in the hospital, and yet there is an urgent need for the improvement of this service in many institutions. Hospital managements and medical staffs should direct attention to the organization of an efficient, ethical pharmacy which will insure safety and the best service possible to the patient. As a helpful guide to this end, the five principles have been embodied in a Minimum Standard for Hospital Pharmacies.

As noted in the requirements of the standard, the pharmacy should supply all drugs to both in-patient and out-patient services, whether they be manufactured stock drugs and solutions or prescriptions. The most effective means of securing efficiency and economy in this department is the adoption of a well-compiled hospital pharmacopeia that will facilitate uniform prescribing of drugs and limit them to the official pharmaceutical preparations. Some hospitals have applied this plan most successfully with results beyond all expectations.

The law in most States and provinces requires that only licensed pharmacists may compound prescriptions, and this law should be strictly observed. A pharmacist may be on a full-time or part-time basis as required, and he alone should be allowed to dispense prescriptions. If the amount of work does not warrant the employment of a pharmacist, arrangements should be made with one in a convenient commercial pharmacy to dispense all prescriptions, the hospital possibly maintaining a drug room from which stocks of prepared drugs are issued. It may be found advisable in some hospitals to employ a part-time pharmacist who spends a few hours each day at the hospital.

The physician's order for drugs should be written in duplicate, the original being sent to the pharmacy and the duplicate retained on the floor. Keeping such a record in the pharmacy is a legal requirement often ignored. All prescriptions are then numbered and filed serially in one of the prescription files designed for use in a commercial pharmacy.

Because of the serious responsibility of supplying a reliable pharmacy service in hospitals, every institution should endeavor to comply as far as possible with the essential requirements embodied in the minimum standard on the opposite page.

### *Ambulance service*

Hospital managements are urged to insist that ambulances serving them be properly equipped and operated. The right kind of first aid and transportation is particularly important, since lack of care at this stage may result in so much harm that the best of subsequent medical and surgical service may be unavailing.

Each hospital management and a committee of the medical staff should cooperate actively with organizations conducting ambulance service in order to insure that the indicated equipment is provided and that the ambulance personnel is properly trained. Since doctors and trained ambulance staffs will not always be on hand before injured persons are moved from the site of the accident, it is also of great importance that policemen, firemen, safety crews in industry, and the public generally be informed as to what constitutes safe first-aid practices and safe transportation. The slogan, "Splint 'em where they lie," should be popularized and applied whenever indicated, and when fractures of the long bones exist, traction splints should be used. Neither medication nor antiseptics should be dispensed by lay ambulance attendants. Plain sterile dressings should be placed over the injuries to avoid further contamination, and cleansing of the wound should be left to the skilled surgeon.

Morphine and hypodermic syringes must not be kept in the ambulance unless closely guarded and unless a physician is a regular member of the trained ambulance personnel. Shock may be minimized by careful handling and by keeping the patient warm by the use of blankets and other approved methods.

Approved mechanical resuscitators or inhalators, using oxygen and carbon dioxide, are valuable aids when applied by trained operators, especially in cases of gas poisoning. These mechanical aids, however, should not replace prone pressure artificial respiration, the method which is of first choice and which is always available.

On account of the nature of the service, the state of cleanliness of an ambulance must be acceptably maintained. At frequent intervals the inside of the



ambulance should be washed thoroughly with soap and water, and vacuum cleaned where indicated. After each trip the used supplies, sheets, bandages, etc., should be replaced immediately with fresh supplies, one of the ambulance personnel being responsible for maintenance of equipment.

The ambulance personnel should consist of a driver qualified in first aid, and a physician or trained attendant. The equipment should include stretchers, clean sheets, blankets, sterile dressings, bandages, towels, adhesive tape of varying widths and lengths, cravat or fracture bandages, traction straps, cotton sheet wadding, wooden tongue depressors, 16-ply clothesline, wooden splints, a Murray-Jones arm splint, a Thomas ring splint, or a Keller-Blake hinged half-ring splint. Obviously, the mechanical condition of the ambulance—tires, brakes, lights, motor, etc.—must be so maintained as to insure prompt, safe, and uninterrupted service. All calls must be answered promptly and this presupposes that there is a personnel covering the 24-hour period.

### *Minimum Standard for Nursing in Hospitals*

1. Organization: There shall be a well organized department of nursing in the hospital, under competent supervision and direction, for the efficient administration and rendering of the nursing service, and for the education of student nurses when a school of nursing is maintained.

2. Personnel: There shall be an adequate number of competent trained personnel for supervision of the nursing service and for efficient nursing care of the patients.

3. Facilities: There shall be adequate and conveniently arranged modern facilities and readily available standard supplies for furnishing prompt and efficient nursing service.

4. Education: When a nursing school is maintained in connection with the hospital, it shall provide definite educational requirements in accordance with accepted national standards, adequate teaching personnel and facilities, and a comprehensive system of school records.

5. Records: There shall be maintained an extensive system of nurses' clinical records, including all data pertaining to the nursing care of the patient, observations of signs and symptoms, orders executed for physicians, nursing services rendered, and other pertinent information that will show the condition of the patient and the response to treatment.

6. Conferences: Weekly meetings of the graduate nursing staff shall be held to review and analyze the nursing service, to determine the quality of the nursing care rendered to patients, and to increase the efficiency of the nursing service when indicated.

7. Relation to patients: Due care shall be exercised at all times to insure the safe and efficient nursing care of the patient through proper assignment of duties, competent supervision over student nurses when used to render nursing care, and an adequate ratio of nurses to patients.

### *Nursing*

When the hospital accepts the responsibility for treatment of a patient, it enters into an implied contract to furnish him with adequate and complete scientific care. In the fulfillment of this contract one of the most important duties of the hospital is to provide the patient with nursing service from the time he is admitted until he is discharged.

The section on nursing of the council on professional practice of the American Hospital Association, in cooperation with a committee of the National League of Nursing Education, has stated the essentials of good nursing service as follows:

"The amount and kind of nursing provided by the hospital for its patients should be based on the patient's needs and not upon his ability to pay for this service. In other words, the responsibility of the hospital is to furnish adequate care to all patients regardless of their ability to pay for it. By adequate nursing care is meant the amount of professional care essential to provide the proper professional treatment for the well-being and recovery of the patient, both mental and physical. If the patients desire more than the essentials of good nursing care, they may well be expected to pay for the additional service."

The importance of efficient nursing service cannot be overemphasized and has a marked bearing on the end results in the treatment of the patient. Unless the physician can have the assistance of good nursing in carrying out the treatment ordered for his patients, he is much handicapped in the practice of his profession.



**Organization:** The first requirement of the minimum standard for nursing emphasizes the importance of good organization. The department of nursing must be as well organized as other departments of the hospital so that there will be a clear definition of authority, responsibility, and functions in order that efficient nursing care may be assured to the patient. This involves executive and administrative ability on the part of the director of nursing, who should organize the department along acceptable and practical lines. While nursing service is a distinct function performed by specially trained individuals, the work must nevertheless be planned and conducted to support and coordinate other services in a larger and more complete organization. The plan of organization should be determined by the size and nature of the institution, and though it may vary from time to time, the underlying principles should have a basic character. As in other departments, well-considered rules, regulations, policies, and procedures, with which each employee should become familiar, must be established for the administrative and technical guidance of the personnel.

**Personnel:** Different types of personnel are required in the hospital to render nursing care, as it varies from the highly specialized technical procedures of the skilled graduate nurse to the nonprofessional services performed by adjunct personnel. An analysis of nursing service as required in the care of patients may be divided into professional and nonprofessional duties which must be assigned to persons who are properly trained to perform them.

1. **Director of nursing service:** The director of the nursing service is the administrative head in charge of all members of the personnel who render nursing care in the hospital, including the special nurse employed by the patient. When the hospital conducts a school of nursing, the director may also be the principal of the school, thereby coordinating the nursing activities of the hospital with the educational activities of the school. The director of nurses is, however, primarily an administrator and therefore must have administrative and executive qualifications.

First, she should cooperate with the accounting department in arriving at a budget. This, when approved by the governing body, becomes her authority for expenditures, in accordance with which she employs all of the necessary nursing personnel.

Second, she should select the members of her staff. For the graduate nurse, a certain legal status is established by the requirement of registration in the State and a license to practice her profession. This is, however, only a minimum requirement and does not assure suitability for the specific position. The same general qualifications—age, education, health, personality, and professional experience—must be considered by the director in choosing all the members of her staff.

Third, having selected the personnel, the director of nurses is confronted with management problems that require her to be a capable executive. Discipline must be maintained, the organization must be made effective, and the care of the patient must be up to the standard that the hospital has contracted to give.

The report previously quoted states the qualifications of the director of nurses as follows:

"It is generally agreed that she should be a woman qualified by preparation and experience to conduct a nursing service, a woman of education and refinement, graduated from an accredited school of nurses, possessing qualities of leadership and a personal knowledge of good nursing practice. It is essential that the director of nursing service be a recognized leader in community affairs. Regardless of whether there be a school or not, she should possess teaching ability as in hospitals without schools a staff education program is essential."

In controlling her staff and performing her executive duties the director of nurses should base her judgments on observations and reports. Knowing good nursing practice, she can judge whether or not the patient is receiving good nursing care, even though she may not be present to observe the actual service. Except in the very small hospital her observation must be supplemented by reports from assistants, supervisors, and others in administrative positions who are directly responsible. Such reports may be informal but they should always be informative. The larger the hospital, the less opportunity the director of nurses has for personal observation.

As head of the nursing service, she is responsible for furnishing certain reports to other departments such as those concerned with business management. A record of patients admitted, orders for diets, and similar matters should be sent at once to the dietary department. Wherever reports are necessary for

the smooth functioning of the service, the director of nurses should be meticulous in seeing that they are accurate and promptly submitted.

As an administrator, the director of nurses should be provided with an adequate number of competent assistants so that her own efficiency may not be impaired. Thus, either personally or through an assistant, she will be able to give that close supervision which is necessary for an efficient organization.

2. Assistants to the director of nurses: Nursing-service functions at all hours of the night and day; yet the director of nurses cannot always be actively on duty and she must have assistants to relieve her both during the day and at night.

The appointment of assistants to the director for day relief is necessary in all hospitals. Someone should be in authority constantly to exercise supervision of the nursing service during the absence of the director. She may be on floor duty, the supervisor of the operating room, or any other nurse. What her other duties may be is immaterial so long as she is officially given the temporary authority. As the hospital increases in size, the duties assigned to the assistant necessarily become more numerous and her time becomes more absorbed until in the larger hospitals there are one or more nurses as full-time assistants to the director. In the small hospital where authority is assigned to different persons on duty during the director's absence, the assistant merely has the power to deal with administrative affairs as they arise, and the specific duties of the director are not designated to her. In the larger hospital many duties are specified as the assistant's responsibility, even in the presence of the director. In the very large institution where there are one or more full-time assistants, the duties are assigned in accordance with the demands and the type of organization.

The assistant to the director for night relief is an essential appointment in any hospital. In the small institution the limited experience of the assistant who has supervisory as well as nursing duties may require her to call the director in major matters, but the director should not be called at night for the numerous petty details that constantly arise. In the larger hospital the assistant to the director for night relief, or the night supervisor as she is commonly called, relieves not only the director of nurses but also the administrator. Her authority is not restricted to the nursing staff; it is an administrative authority over the activities occurring at night in the entire institution. Only in the very large institution is there a night superintendent who represents the director of nurses.

The duties of the night supervisor should be definitely assigned and promulgated. Her supervisory responsibilities are the same as those of the director, but limited to the operation of the hospital at night. For coordination between night and day activities, the night supervisor should leave specific reports for the director of nurses, completed immediately before going off duty and containing a concise statement of all important activities for the information of the day staff. While certain formal reports, such as the midnight census, are usually designated, the night supervisor should not confine herself to routine reports.

3. Supervisors and head nurses: Supervisors and head nurses are graduate nurses assigned to manage the administrative detail of nursing care of the floors or divisions. In the very small hospital the director's assistant may be the only supervisor and she will be expected to render a certain amount of nursing service. On the other hand, in the larger hospital the nursing load must be carefully studied and sufficient supervisors appointed to insure the effective performance of duties. The supervisor is responsible for arranging the duties of the personnel assigned to her, for seeing that these duties are properly performed, for maintaining discipline, and for keeping the supplies and equipment in her division up to accepted standards and readily available for proper use.

Service of food to patients is a responsibility of the dietitian, but it is often economically impossible to separate this function entirely from nursing. Customarily, the food as ordered is sent to the floor and the floor supervisor assigns members of the nursing personnel to serve the patients. In every instance, it is the responsibility of the floor supervisor to be certain that the patient is receiving the food ordered by the attending physician.

The assignment and performance of certain housekeeping duties by maids and employees from the housekeeping department should be under the direction of the floor supervisor in order to minimize disturbance to patients. She, however, should report any incidents of improper service to the housekeeper under whom the employee directly works and leave matters of discipline to her.

Head nurses are employed in some large hospitals when it is found advisable to place under one supervisor a larger number of patients than she can possibly



be responsible for in all detail. The head nurses are subordinate to the supervisor and are responsible to her for the actual care of the patients, but all matters of administration are left to the supervisor.

4. Graduate nurses: Graduate nurses employed in the hospital should be legally licensed to practice their profession and they should have the general qualifications required of all members of the personnel rendering nursing service. The committee on the grading of nursing schools has well stated what should be required of a graduate nurse in *An Activity Analysis of Nursing*. This may be summarized as follows:

Irrespective of the special field in which the graduate nurse has elected to practice, she should:

(a) Be prepared to give expert bedside care and she should have such knowledge of the household arts as will enable her to deal effectively with domestic emergencies arising out of illness.

(b) Be competent to observe and to interpret the physical manifestations of the patient's condition and also the social and environmental factors which may hasten or delay his recovery.

(c) Have the special knowledge and skill required in managing situations peculiar to certain common types of illness.

(d) Be able to apply, in nursing situations, those principles of mental hygiene which make for a better understanding of the psychological factor in illness.

(e) Be capable of taking part in the promotion of health and the prevention of disease.

(f) Possess the essential knowledge and ability to teach measures for the preservation and the restoration of health.

(g) Be able to cooperate effectively with the family, hospital personnel, and health and social agencies in the interests of patient and community.

(h) Be able, by the practice of her profession, to attain a measure of economic security and to provide for sickness and old age.

Graduate nurses fall into two classes: The graduate staff nurse and the graduate nurse on special duty.

In view of the higher standards of nursing education, the employment of student nurses to give professional care has been found impractical and unsound economically. As a result, an increasing number of graduate staff nurses are provided for this purpose. It has been found, however, that their time and training are too valuable to require them to perform all of the nonprofessional duties that were formerly assigned to the nursing staff. Gradually their work is being concentrated on giving expert nursing care while housekeeping and similar duties are being performed by less highly trained personnel in the nursing organization.

More specifically, the duties of the graduate staff nurse on general duty consist of the administration of actual treatment covered by standing orders approved by the medical staff or ordered in writing by the attending physicians. The graduate staff nurse should be trained to observe symptoms and to record her observations, but she should not perform duties that are exclusively the function of the physician. Under the present day custom of assigning to less highly trained personnel many of the duties of caring for the patients, it is the responsibility of the graduate staff nurse to see that these duties are suitably performed for the patients.

The graduate nurse on special duty must fit into the general organization of the nursing personnel, even though she is employed by the patient. She should report to the director of nurses when she comes on duty, for she is responsible to her for acting in conformity with the standards of the hospital, and she must satisfy the director that the patient is being properly attended. The graduate nurse on special duty performs all of the duties of graduate staff nurses and also many tasks that are undertaken by less skilled help when the patient is relying on general nursing service. She should have at her disposal help from the subsidiary workers, and in case of necessity she should have the privilege of calling on the general duty nurse for assistance. When she is not on duty or is to be temporarily unavailable, she should notify the supervisor of the floor; the entire care of the patient then devolves on the general duty nurse until her return.

5. Student nurses: Every hospital conducting a school for nurses should have enough graduate supervisors and general staff nurses to give the student nurse proper supervision, to assign to her only those responsibilities for which she has been prepared, and to provide at the same time adequate nursing care for the patient.



6. **Subsidiary workers:** Subsidiary workers are defined as all persons other than graduate registered nurses and student nurses who are employed in the care of the sick. Some call the male subsidiary worker an orderly, others a nurse's aide; nurse's assistant or attendant may be the title of the female subsidiary worker.

Orderlies are assigned to perform for male patients certain duties that are customarily performed for female patients by nurses. Orderlies are not recognized as nurses, but since they are required to perform some nursing services, they should be given special training by the hospital beyond their basic educational requirements.

Attendants, both male and female, are employed by the hospital to perform certain duties for the patient that do not require skill and training. Since the attendant is directly in contact with the patient, he should have more education than ordinary maids and porters and special training in the duties to which he may be assigned. In order to keep the standards of the hospital high and to provide adequate nursing care to patients, the attendant should be strictly limited to the performance of duties that do not require the skill of the graduate nurse. It is generally recognized that the duties of attendants should be specifically stated and that assignment on the floors should be definitely made by the supervisor.

The joint board of directors of the three national nursing organizations, namely, the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing, has compiled and published a bulletin outlining "Principles and Policies in Relation to Subsidiary Workers in the Care of the Sick."

**Facilities.**—In the administering of various forms of treatment recommended by the attending physician, the nurse will require considerable equipment, furnishings, and supplies. These facilities should be so conveniently arranged that they conserve the distance traveled and time consumed in rendering service to the patient. The lack of proper instruments, sterilizing equipment, special apparatus, and the like may greatly handicap the expedition and the efficiency of good nursing service. The growing tendency toward centralization and standardization of supplies has led to the installation of the central supply room which services the various nursing units. If this service is well organized, it is more conducive to efficiency and economy in the use of supplies.

**Education.**—When a hospital decides that it is justified in maintaining a school of nursing, it must consider carefully its obligations to provide the educational facilities as well as the proper living conditions that will attract applicants who can meet the nursing requirements of the present day. Adherence to national standards as promulgated by the National League of Nursing Education is essential. Just as the hospital finds that it is necessary to limit the selection of students to those of high mental, physical, and moral standards, so it must also provide a course of instruction of such standard that the cost must become a reckoning factor of increasing proportions. No hospital should undertake a school of nursing without adequate teaching facilities—classrooms, demonstration rooms, and laboratory with essential equipment; a teaching personnel of at least 5 graduate nurses; and a daily average of not less than 75 patients in order to provide a sufficient range and variety of clinical material which is most desirable in the teaching of student nurses.

The prevailing educational requirements for admission to schools of nursing include at least graduation from high school or its equivalent. Even in those States where the State board of nurse examiners does not require the registrants to be high-school graduates, the majority of hospitals have voluntarily established these educational requirements for admission to the school of nursing. An additional 2 years of college work or a college degree is desirable. The course of training in the hospital should not be less than 3 years, including a minimum of 4 months' preliminary instruction, and should provide at least the curriculum in theory and practice required by the State board of nurse examiners.

**Records.**—Records are as essential in the nursing department as in all of the other departments of the hospital for keeping a clear account of the duties performed by the graduate nurse and the educational record of the student nurse.

The school of nursing record of the individual student consists of one of the acceptable systems in use which shows the amount and types of theoretical instruction and clinical experience of the student from the time of her admission, her standing, final grades, and eligibility for examination by the State board.

The nurse's section of the medical record consists of the graphic chart, physician's orders, orders for treatment, and record of treatment and symptoms.

The graphic chart is used in many variable forms, although the data recorded are essentially the same. The chart shows primarily the graphic record of temperature, pulse, and respiration for the days the patient is hospitalized. Additional entries, such as operation, hemorrhage, delivery, and similar occurrences, should be strictly limited.

Physician's orders should be entered on a prescribed form, either written by the physician or dictated and signed by him. The more common systems of securing these written orders are as follows:

1. A page attached to the chart on which the physician writes his orders.
2. A blank bound book in which orders are written.
3. A standard prescription record.

The disadvantage of the first two systems far outweigh the advantages. They do not permit sending the original prescription to the pharmacy as required in most States. Moreover, the pages soon become illegible and it is difficult to differentiate the canceled orders from the standing orders. The third system is a record bound in book form with duplicate pages; the original page is perforated to form four order blanks. When the book is filled, the carbon copies should be properly labeled and sent to the medical-records office for permanent filing.

The orders written by the physician should be transcribed by the nurse to a form entitled "Orders for Treatment." The body of the form is divided into two sections, the left for medication and the right for diet and other treatment. In each half, space is allowed for the dates and the detail of the order. Under medication, prescriptions should be copied in full as soon as they are received. Orders for routine diet should be entered according to the standard designation, but the complete order should be transcribed for special diets and other orders.

The nurse's report of what she has done and what she has observed should be contained in the record of treatment and symptoms. The hour at which treatment was given, all medicine and diets, and the nurse's personal observations should be recorded in concise form.

Nurses' notes constitute an important part of the medical record and should be preserved as an integral part thereof. The practice of destroying nurses' records is not approved. When the American College of Surgeons inspects a hospital, consideration is given to the nurses' records as well as to those of the physician, radiologist, pathologist, and others. One of the most important duties of the nurse is the accurate recording of data pertaining to the condition of the patient, especially with reference to the symptoms which she observes. By this means she becomes a valuable collaborator with the physician in his efforts to study and combat disease as evidenced by the symptoms. Every nurse should be given special training in the compilation of bedside records and should be taught how to observe accurately and express herself concisely. If nurses' records are up to the required standard, they offer valuable information and serve to round out the entire medical record.

*Conferences.*—The nursing staff should hold conferences for the appraisal of its activities to determine whether or not the nursing service is adequate and what can be done to keep it on a high plane of efficiency. Such meetings tend to arouse a deeper interest in good nursing service, add to the nurse's knowledge of her professional work, and generally help the medical service and administration. These conferences should be held regularly once a week for an hour; a definite program should be followed, and minutes should be kept of the discussion.

*Relation to patients.*—It is quite obvious that due care must be exercised in the assignment of nurses and adjunct personnel to patients. This applies particularly to the student nurse who may not be qualified to do many of the nursing procedures required in her tour of duty. Therefore, the careful assignment and supervision of her work is imperative. Furthermore, the utmost caution must be exercised in order that adjunct nursing personnel or subsidiary workers limit their activities to nonprofessional duties.

Of vast importance is the ratio of nursing personnel to patients. This varies considerably in different institutions because of the numerous factors involved. Many attempts have been made to arrive at a standard ratio of nurses to patients, but variation is so great in the type of patient admitted and in the conditions under which the nursing personnel care for them that the same figures cannot be made applicable to any two hospitals. If averages are used as a guide, the nursing load of each institution and of each department in it can be studied, and then members of the nursing staff can be given a flexible assignment to meet the load as determined.

The department of studies of the National League of Nursing Education has made studies of the bedside nursing time required for various types of patients and the figures in table I are quoted as a guide.

TABLE I.—Average hours of bedside nursing in each 24 hours

Adult		Obstretical		Pediatries		
Medical	Surgical	Mothers	Infants	Infants	2-5 years	5 years and over
3-3½	3-3½	2½-3	2½-3	6	4½	4

Considering the distribution of nursing on this basis in a hypothetical hospital under ordinary conditions, table II would be a schedule of nursing personnel required for a minimum and maximum number of nursing hours. This table is a modification of two tables prepared by the department of studies of the National League of Nursing Education.

TABLE II.—Nursing personnel and other workers required when the minimum and maximum of the recommended number of bedside nursing hours are provided

Type of service	Type of ward	Bed capacity	Daily average patients	Head nurses	Graduate bedside nurses	Ward helpers <sup>1</sup>	Orderlies <sup>1</sup>	Bedside nursing hours per patient in 24 hours
Medical and surgical:								
Women.....	Ward.....	26	21	1	9-11	2		3 -3½
Men.....	do.....	26	21	1	9-11	1	3	3 -3½
Children's.....	Private, semiprivate and ward.	14	11	1	8-8	1		5
Mixed.....	{Private.....	16	13	1	{ 8-9 6-7 }	2	3	{ 4 -4½ 3 -3½ }
	{Semiprivate.....	18	14					
Maternity:								
Beds.....	{Private.....	<sup>2</sup> 13	10	1	{ 5-6 4-4 7-9 }	2	1	3½-4 2½-3 2½-3
	{Ward.....	12	10					
Bassinets.....		25	20					
Total.....	All wards.....	150	120	5	56-65	9	6	

<sup>1</sup> It is assumed that there will be the number of workers listed in this column on the ward during each 24 hours. In a 6-day week, 1 relief worker is required for each 6 workers.

<sup>2</sup> Includes 1 isolation room.

However, it is always advisable in determining the ratio of nurses to patients to make a careful study of the nursing load of the individual hospital. This will vary not only according to type of patient and worker but also according to the variation in the work load throughout the day in the hospital. It is quite obvious that more nurses will be required in the morning in order to cope with the work, and the number will gradually diminish through the afternoon and evening. The distribution of the nursing service should therefore be based on a careful analysis of the work load.

#### *Minimum Standard for Dietary Departments in Hospitals*

1. Organization: There shall be a properly organized dietary department under the direction of a competent graduate dietitian whose training conforms to standards approved by the American Dietetic Association, this department being responsible for: (a) the efficient administration of the general food service, (b) the scientific diet of patients, and (c) the education of the student nurse or the student dietitian in hospital dietetics.

2. Facilities: Adequate administrative and teaching facilities shall be provided for the dietary department, including in particular: (a) the necessary accommodations and equipment for the dietitian's office, kitchens, storage rooms, re-



frigeration, and other service requirements, and (b) a well equipped classroom and laboratory for the education of student nurses or student dietitians when a school of nursing is attached to the hospital or there are student dietitians in training.

3. Personnel: There shall be an adequate administrative and technical staff competent in their respective activities, and conforming to proper physical, mental, and character standards.

4. Records: A comprehensive system of administrative, financial, clinical, and technical records shall be provided and correlated so far as necessary with medical and other records of the hospital.

5. Policies: The director of dietetics and staff, with the approval and co-operation of the superintendent or director and governing board of the hospital, shall initiate and develop rules and regulations pertaining to the administrative and professional policies of the department. These rules and regulations shall specifically provide for departmental and interdepartmental conferences at regular intervals to review the work of the dietary department for the purpose of improving the service which is rendered and its general efficiency.

### *Dietary department*

During recent years there has been a remarkable advancement in food service in hospitals and now dietetics is recognized as an important specialty. All patients, whether bedridden or convalescent, and whether or not they are suffering from disorders of metabolism, require special and scientific dieting. All employees, regardless of their positions in the hospital, should have the benefit of proper scientific food service. To meet these needs, hospitals have not only given much thought to the administration of general and special diets, but they have made extensive studies to determine the most economical and efficient methods of handling food.

Every approved hospital requires a well organized dietary department; therefore the American College of Surgeons has formulated certain fundamental and guiding principles with respect to its administration. These principles are expressed in the Minimum Standard for Dietetic Departments, which follows.

*Organization.*—It is imperative that the department be under the direction of a competent graduate dietitian if it is to function to the greatest advantage. Although the science of dietetics is comparatively new, it has proved to be of such therapeutic value that the services of a trained administrator are almost indispensable. As a result, the dietitian who is head of the department is recognized as one of the senior administrative officers, and is therefore responsible directly to the superintendent. In order to carry this responsibility, she must possess the qualifications which are specified by the American Dietetic Association. Summarized briefly, these qualifications are:

1. Graduate of a recognized school of home economics which provides a theoretical knowledge of food chemistry, physiology, and hygiene.
2. Practical training in a hospital approved for such a course where the dietitian will have learned to prepare and serve diets.
3. Administrative ability and training which enables the dietitian to organize her staff and its work so as to produce the best possible results at the least cost.
4. Business ability developed through training which makes it possible for the dietitian to manage properly and prevent waste.
5. Knowledge and judgment of a purchasing agent, whether she actually buys or not.
6. Mechanical turn of mind to appreciate the machinery in operation in her department and to have it used to the best advantage.

It is obvious that the successful dietitian is confronted with numerous problems, such as scientific diets, organization, planning, equipment, food buying, storage, and accounting. She must be an economist and an administrator as well as a scientist if her department is to be highly efficient.

The duties of a dietitian may be classified into three groups: administrative, scientific, and educational.

The administrative duties occupy a large portion of her time and ordinarily include:

1. Planning menus for patients and personnel.
2. Collaborating in purchasing food supplies and kitchen equipment.
3. Supervising the preparation of food.
4. Directing the task of serving meals promptly and attractively.

5. Keeping accurate records.
6. Directing all employees who are connected with the dietary department.
7. Regulating the food budget so as to effect every possible economy and at the same time maintain a high standard of food service.

The scientific duties of the dietitian are concerned with diet therapy and include:

1. Planning of general diets.
2. Planning menus for patients on special diets.
3. Supervising the preparation of special diets in respect to food values and appeal to the appetite.
4. Inspecting special trays before they are sent to the floors.
5. Checking and weighing food returned on special trays to determine patient's reaction to food and to record the intake.
6. Directing and supervising nutrition for out-patients.

Since the dietary department is recognized as a definite therapeutic unit of the hospital, the dietitian must work in close cooperation with the medical staff. In general diets, the routine diet lists of the hospital enable the physician to order the type of food that will supplement his other treatment. In the observation, diagnosis, and treatment of many diseases, the physician will modify the general diet list by special order. With few exceptions, the physician orders the diet in general terms, leaving the detail to the dietitian who has become a most valuable aid to the clinician in the scientific practice of medicine.

The dietitian's scientific duties bring her in close association with the laboratory worker; therefore a good working relationship must exist between the clinical laboratory and the dietary department.

The educational duties of the dietitian include:

1. Teaching student dietitians in accordance with the standards formulated by the American Dietetic Association.
2. Instructing student nurses in the principles of dietetics.
3. Instructing medical students in the principles of diet therapy.
4. Teaching patients proper dietary habits.

In addition to her administrative, scientific, and educational functions the dietitian is receiving increasing recognition in the promotion of health and the prevention of disease. Not only does her influence affect the health of the individual patient, but her contact with the family, the school child, the student, and various other groups whom she educates along the lines of sound dieting, guides their future physical condition. More and more is the dietitian assuming a status in the out-patient department. Here the nutrition clinic, an innovation of recent years, renders a most valuable service in the care of ambulatory patients. In this clinic, the dietitian has opportunity to assist the clinician in guiding the course of diet for the patient. Patients are referred to the clinic for consultation and advice regarding the diet to be followed in the treatment of their disease.

Some hospitals of less than 50 beds may conclude that they cannot afford to employ a dietitian, but inasmuch as food service involves about one-third of the total expenditures of the hospital, few institutions can afford to be without a well trained dietitian.

*Facilities.*—The physical requirements for modern food service should include not only the necessary space for kitchen, storage, refrigeration, special diet kitchen, dining room, and possibly preparation rooms and bake shop, but should also take into consideration the important factors of location, lighting, ventilation, heating, steam, water and fuel supply, transportation of food, dishwashing, and garbage disposal. If the hospital is a teaching unit for student nurses or student dietitians, there should be a diet laboratory and a well equipped classroom for didactic teaching.

*Personnel.*—The personnel of the dietary department should consist of the administrative and technical staff. Besides the dietitian, other employees should be skilled in the preparation and service of foods, and the duties of the skilled and unskilled should interlock accurately in order that food of good quality may always be ready for service at stated hours. Recent studies have shown that the average general ratio of dietitians to patients is approximately 1 to 100, and that in hospitals of 250 beds and over the ratio is a 0.75 to 100. As there are many hospitals of 50 beds or less employing dietitians, it is obvious that their work will include assignments outside the dietary department. In larger hospitals the number of assistant dietitians and other employees, such as chefs and assistant chefs, waitresses, maids, porters, and kitchen help, should be determined by such fac-



tors as the average number of patients, number of special diets, type of service, extent of instruction, and physical conveniences of the department.

*Records.*—The department which does not keep records of its operations is handicapped. The recorded data should consist of administrative, business, technical, and clinical notations. A proper system of administrative and business records gives the dietitian basic information on unit costs. Graphs may be compiled from these records to serve as guides in purchasing and to teach student dietitians. Technical records should contain notations on food values and other data, compiled for reference in the preparation of diet. Clinical records should pertain to metabolic or diet therapy cases and includes a report of the intake and output in relation to sugar, blood urea, and other elements indicated in different types of diseases in which special diets are used. The dietitian will need her own file of laboratory and other findings to use as a guide in her work. The record, moreover, will be a means of correlating the work of the dietitian, the clinician, and the laboratory worker to the end that more rational treatment will be administered.

*Policies.*—The dietary department of the hospital comes in contact with numerous departments in rendering its service and there should be the utmost coordination and cooperation in order to assure efficiency. Therefore definite and clearly stated department rules, regulations, and statement of policies, with the setting forth of duties and relationships, are essential, and with these each worker in the department should be familiar in order that the greatest efficiency may be maintained, and that the dietary service may supply the increasing demands of hospital service and scientific medicine.

### *Minimum Standard for Medical Social Services in Hospitals*

1. Functions: The activities, in which the social-service department may appropriately engage and which should be developed in close collaboration with the medical staff, shall be the following: (a) the practice of medical social case work; (b) the development of the medical social program within the medical institution; (c) participation in the development of social and health programs in the community; (d) participation in the educational program for professional personnel; and (e) medical social research.

Medical social case work involves the study of the individual patient's social situation, interests, and needs in relation to his illness, and the medical social treatment of the patient in collaboration with him and his physician when those social needs and interests affect the physical and mental health of the patient.

2. Organization: The medical and social service departments shall be closely integrated in relationship and organization. There shall be one director or executive head of the social-service department who shall be responsible to the executive officer of the institution and through him to the board of management.

Funds for financing the social-service department shall come from the hospital treasury. The budget recommended by the director of the social-service department and allocated by the administrator for that department shall be controlled and administered by the director of the social-service department.

3. Facilities: Provision shall be made for a central office for the social-service department, and for such individual offices as the professional staff, in the performance of its social-work activities, may require. The offices shall be accessible to patients and to doctors but shall afford privacy for interviews.

4. Records: It is essential that the social-service department keep records of its work with patients and thus preserve such information as is relevant to medical social study and treatment. Since medical social records are a part of the professional data of the hospital, they shall be available only to professional personnel concerned with the treatment of the patients.

### *Medical social service<sup>1</sup>*

Medical social service has been developed in the hospital as a service to the patient, the physician, the hospital administration, and the community, in order to help meet the problem of the patient whose medical need may be aggravated by social factors and who, therefore, may require social treatment which is based on his medical condition and care.

It has long been recognized by practicing physicians that many social elements play an important part in the incidence and control of disease and that there is need to know the patient as an individual person in relation to the environment

<sup>1</sup>Basic material extracted from Statement of Standards for Medical Social Service Departments, adopted by the American Association of Medical Social Service Workers, May 1936.



in which he lives and works, his capacity to understand and participate in a plan of medical treatment, his obligations, and his material and personal resources. Nevertheless, the physician sees his patient in a hospital or clinic where the patient is isolated from his natural environment, and the physician is hindered from understanding as fully as is desirable the social factors that may be contributing to the patient's illness or retarding his treatment and convalescence. It is important to know how effectively the clinic or hospital patient can use the resources of the medical institution and of the community, and it will often be necessary to assist him to carry out the plan of treatment advised by the physician if he is to have as early and as complete restoration to health as possible.

The selection of well qualified personnel who have adequate preparation through professional education and experience in the specialized field of medical social service is essential for the fulfillment of the activities to be defined in this statement. Therefore, the director of the social service department herself should be a person with these qualifications and she should appoint to positions on her staff those who have had such preparation. Since the requirements for membership in the American Association of Medical Social Service Workers are changing from time to time in accordance with the demands of the field, they are suggested as criteria for selecting directors and staff workers.

*Functions.*—The following activities should be developed by the social service department:

1. Practice of medical social case work.
2. Development of the medical social program within the medical institution.
3. Participation in the development of social and health programs in the community.
4. Participation in the educational program for professional personnel.
5. Medical social research.

In order to carry on the activities of the social service department, the personnel should be engaged in medical social case work, even though the number of patients receiving comprehensive medical social treatment may be limited at any one time. Certain services that might be considered largely administrative may properly be considered forms of medical social case work when the individual patient and his problem are studied together, and when the need for more comprehensive medical social case treatment is recognized and secured for the patient; for instance, in the social admission of patients to the hospital or outpatient department; the social review of all patients in a given area, such as a ward, a clinic, or a diagnostic group; and certain types of follow-up.

Medical social case work may range from a simple and abbreviated process to a full and comprehensive one. Such considerations as the need in each individual case, the decision by the doctor and the worker to treat all or a part of the problems presented, the limitations set by the administration, and the availability of community resources determine the degree of service to be given. Social study and treatment may be carried on entirely by the social service department or in cooperation with another case working agency, in continued collaboration with the physician. A department should give evidence of steady growth in quality of work, experimentation with new ideas, and development of new methods.

When there is a recognized need for considering the patient as an individual person in his relationship to the many and varied procedures within the hospital, the social service department should consider the patient's needs with the administration, the medical staff, and the various other professional departments involved, and to help formulate policies affecting those procedures. It is appropriate for the social service department to initiate social and health programs in the community and to participate in planning and developing such programs. In community planning relationships, representatives of the social service department should constantly test their thinking with that of the administration and the medical and other professional staffs.

The social service department may be selected to collaborate with schools of social work in carrying out the educational program for medical social students and to provide field work opportunities for medical social students and other students of social work. The social service department will also be expected to secure further educational opportunities for its own professional staff. For medical, nursing, and other professional groups within the hospital, the social service department may, on the request of the responsible head of the group and

with the approval of the hospital administrator, participate in courses or conferences designed to focus on the social aspects of illness. A free interchange of thought regarding the special method and technique of each professional group is necessary, in order that the patient may derive the most benefit from the integration of the various services offered by the institution. For those patients whose needs require medical social case work, the social service department itself will be responsible for that case work and for supervising other professional personnel who may be participating in such treatment for educational or other reasons.

The members of the staff of the social service department should approach practice with an inquiring mind, alert to the value of studying those problems which recur in their own practice, and ready to collaborate in study projects undertaken by related professions, by community agencies, and by others in the field of medical social work. When funds are available, individual members of the social service staff may be released from their duties for particular research projects.

*Organization.*—It is important that the medical and social service departments be closely integrated in relationship and organization. There should be one director or executive head of the social service department who should be responsible to the executive officer of the institution and through him to the board of management.

Funds for financing the social service department should come from the hospital treasury. If the department has had to receive money from other sources, the hospital authorities should try to finance the department as soon as possible. The budget recommended by the director of the social service department and allocated by the administrator for that department should be controlled and administered by the director of the social service department.

The department should consider the use of carefully selected and supervised volunteers to whom may be delegated tasks within their individual capacities. The social service department should also consider the value of having a committee made up of lay and professional persons who are interested in studying the work of the department in its relationships within and outside the hospital, and who will act in an advisory capacity in developing new projects and in furthering the broad understanding of the department's work by those responsible for its support.

*Facilities.*—A central office for the social service department and individual offices which may be required by the professional staff in the performance of its social work activities should be provided. The offices should be accessible to patients and to doctors but should afford privacy for interviews. For its efficient operation, the social service department needs to have adequate clerical assistance, filing space, office equipment, telephones, and means of transportation.

*Records.*—The purposes of recording are: service to the patient, education, and research. Medical social records serve to facilitate planning with the physician the medical social treatment to be given, and judging with him the effectiveness of the medical social treatment already given.

There should be a full medical social record filed as a part of the unit medical record or separately, according to the practice of the individual hospital. When it is separately written and filed, it should contain medical information pertinent to the social situation. Social service notes may also be included among the medical progress notes or on a consultation sheet in the medical record if there is social information that pertains to the physician's care of the patient and if the notes are succinct and carefully chosen from the standpoint of the physician's interest.

Since medical social records are a part of the professional data of the hospital, they should be available and easily accessible only to professional personnel concerned with the treatment of the patients, with the understanding that there will be consultation with the medical social worker responsible, so that amplification and interpretation may be given by her after the consultation with the physician.

The social service department should keep a statistical count of its recorded cases. For this purpose, there is strongly advised the plan outlined by the committee on statistics of the American Association of Medical Social Workers, and the United States Children's Bureau. Other statistical material may be added in accordance with the special interests of the individual institution.



*Minimum Standard for the Hospital Medical Library*

1. **Content:** All general hospitals shall maintain an adequate medical library comprised of a basic collection of carefully selected, authoritative medical textbooks and reference works of the latest edition, and files of current journals, including those which most effectively reflect recent developments in medicine, surgery, and those specialties, which are represented in the clinical services of the hospital.

2. **Housing:** The collection shall be housed in or adjacent to a convenient reading room furnished in such a manner as to encourage study and research. It shall be classified and arranged so that it is easily accessible to the librarian and members of the medical staff.

3. **Personnel:** The library shall be under the supervision of a qualified librarian. She shall act as custodian of its contents, and also shall arrange for the necessary cataloging and indexing which will enable the resident staff to do reference work quickly and easily. Assistance in the preparation of bibliographies, translations, abstracts, and reviews of the literature shall be made available either by employing a full-time research librarian or by the use of the extension facilities offered by larger libraries.

4. **Extension facilities:** The librarian shall provide information and brochures describing the facilities that are offered to members of the medical profession by the staffs of specific libraries which have been established on a more extensive basis in order to supplement the work of the local librarian and to serve the literary needs of professional men regardless of their location.

5. **Committee on the library:** Selected members of the medical staff shall function as a permanent committee of the library, and their duties shall be to foster and develop the resources and interests of the library and to encourage the use of its facilities.

*Hospital medical library*

**Content.**—With the rapid growth of medical literature in recent years and the many demands which are being made upon the time of members of the medical staff and interns, every general hospital should maintain at least a small medical library within its own walls. The purpose of the library is to make easily available to members of the staff medical literature presenting standard procedures as well as that which is descriptive of the most recent developments in medicine, surgery, and the specialties represented in the services of the hospital. Textbooks and reference works of late edition are essential for ready reference with respect to standard procedures. However, since new developments are presented first in current journals, each hospital medical library should be equipped with a broad selection of journals covering the literature of the last five years and with the indexes which will make the contents of those journals evident. The size of the collection will depend upon the size of the hospital, the availability and use made of other library facilities, and the specific needs of the staff. A hospital having more than one hundred beds and dependent upon its own resources for filling the immediate needs of the staff, should have as its aim a collection of 1,000 volumes. Reference may be made to a list of textbooks, current medical journals, and monographs prepared and published by the department of literary research of the American College of Surgeons which will be revised from time to time.

**Housing.**—The collection of books, reprints, and journals should be housed in or adjacent to a conveniently located reading room. It is frequently found advisable to place the reading room near to the medical records room for the convenience of both readers and librarians. The room should be cheerful and attractive and equipped with study tables, proper lighting, and other facilities that will encourage study, research, and the reading of recently received issues. The textbooks should be classified and arranged on the shelves with the bound journals in such a manner as to be easily accessible to the librarian and to members of the medical staff. Current issues should be arranged upon open shelves or tables where they will attract the interest of the regular or casual visitor.

The library should be open to readers at least 8 hours each day; when the librarian is not on duty, the key should be left with the medical records librarian or a responsible office secretary.

**Personnel.**—The library should be under the supervision of a qualified librarian who will devote at least half time to this work. She should arrange for the necessary cataloging and indexing of the textbooks and monographs and for the binding and shelving of the current journals. As custodian of the collection she



should keep a record of all books and journals loaned and of their return in accordance with the rules adopted by the hospital administrator in conjunction with and through the action of the committee on the library. She should maintain a record of journal issues currently received in the library and notify the publishers of any discrepancies, either directly or through the hospital purchasing department.

Assistance in the preparation of bibliographies, translations, abstracts, and reviews of the literature should be made available either by employing a full time research librarian or by the use of the extension facilities offered by larger libraries prepared to serve a widely distributed clientele. In the larger institutions it may be necessary to supplement the services of the full-time research librarian with the extension facilities. In many hospitals, the librarian will be able to supply a limited research service, but if more extensive studies are desired, they should be carried on with the assistance of staffs especially equipped to do this work. A hospital medical librarian may not have an extensive collection of indexes to assist in compiling complete bibliographies or a wide knowledge of foreign languages as a basis for translating. Again many foreign journals will not be available to her locally, nor will she have in her collection the early monographs required for a historical study. These aids she may obtain through the various services of larger libraries.

*Extension facilities.*—The librarian should be familiar with and have on file literature concerning the services offered to members of the medical profession by the library and department of literary research of the American College of Surgeons, the library of the American Medical Association, the library of the American Hospital Association, the Surgeon General's library, and through general interlibrary loan. Each library listed offers a different type of service and, in order that the hospital medical librarian may adequately advise how a specific need can be met, she should familiarize herself with these services, visit medical libraries in her vicinity, and keep abreast of the latest developments in her field by attending the annual meetings of the Medical Library Association.

*Committee on the library.*—This committee may consist of three to five persons selected from the members of the medical staff who should function as a permanent committee. An interested member of the governing board might also be included on this committee. The duties of the committee are to foster and encourage contributions in support of the library and to act with the hospital administrator and the librarian in the formulation and the enforcement of rules governing the use of the library. The committee should act also in an advisory capacity with respect to the purchase of textbooks, reference works, monographs, and journals, and in the solution of administrative problems of the library. Finally, it should aid in developing the library and in encouraging the use of its facilities by those who are entitled to that privilege.

#### STANDARDIZATION OF THE SMALL HOSPITAL

##### *Fundamental principles in the standardization of the small hospital*

1. A physical plant, free from hazards, and providing, either within the hospital or by affiliation with a larger institution, all facilities which are practicable and possible for the care of the patient.

2. Clearly stated constitution, bylaws, rules, and regulations providing for a governing board, a medical staff, and such administrative officials as are warranted by the size of the hospital.

3. A medical staff which may or may not be divided into specialties or clinical departments, depending on local conditions but if possible embracing at least medicine, surgery, obstetrics and gynecology, and the specialties of eye, ear, nose and throat.

4. Medical staff conferences, monthly or more frequently, for the thorough review and analysis of the clinical work based on the medical records, and embracing deaths, unimproved cases, infections, complications, errors in diagnoses, results of treatment, and an analysis of clinical reports.

5. Accurate and complete medical records written for all patients admitted to the hospital, and each containing sufficient data to justify the diagnosis and to warrant the treatment.

6. A clinical laboratory providing a complete and properly supervised service, including at least the minimum or emergency service within the institution, and the major or more complicated service through acceptable affiliation when necessary.

7. An X-ray department providing a complete and properly supervised X-ray service, including at least the minimum or emergency service within the institution, and the major or more complicated service through acceptable affiliation when necessary.

The minimum standard requirements are readily applicable to the small hospital and are of inestimable value in establishing proper organization and administration to care efficiently for the sick and injured.

Governing boards of small hospitals are urged to adopt the principles of the Minimum Standard for Hospitals. The fact that a hospital has only 25 or 30 beds should not prevent it from qualifying for approval. Too frequently the management of the small hospital is of the opinion that approval is based on an elaborate physical plant and expensive equipment; but this is not the case. In most instances the small hospital, with a modern building and equipment sufficient to satisfy the demands of an enlightened public and to exist in the community, can readily meet the requirements in this respect. The surveys of the American College of Surgeons reveal that the usual deficiencies of the small hospital are especially related to matters of medical staff organization, staff meetings, medical records, and the proper supervision of the various clinical departments, all of which may be corrected through the united efforts of the medical staff and hospital management. A prohibitive financial outlay is not involved. It is a problem of organization and performance, not of physical plant and equipment.

It is to be expected that certain difficulties may be encountered in meeting the requirements in the small hospital, but in every instance adjustments can be made and a practical and acceptable plan worked out. Frequently some of the services (particularly clinical laboratory and X-ray) may have to be supplemented from outside sources, but in spite of the difficulties encountered, a considerable number of small hospitals are creditably fulfilling the minimum requirements.

#### *Medical staff organization*

The small hospital can easily have an organized medical staff. Experience has proved beyond a doubt that organized effort in conducting the medical work of a hospital is absolutely essential, regardless of how limited a number of physicians may be privileged to practice in the institution. When there are even as few as three or four physicians, medical staff organization may exist in its simplest form—an undifferentiated group. Provision should be made for the periodic election of officers who function in an executive capacity in matters pertaining to the medical work of the hospital. This type of medical staff organization usually applies to the small privately owned hospital, to the specialized sanitarium, or to the institution owned by an industrial corporation, the medical staff of which is employed on a full-time or part-time basis, and the organization of which is simple yet essential to the proper conduct of the medical work.

In the small community or church hospital privileges are usually extended to a group of physicians practicing locally, and sometimes to an additional number from the surrounding communities who refer or occasionally care for patients in the hospital. There are also consultants who are more or less regularly called from nearby cities. It has been found advisable under these circumstances to divide the medical staff into groups; and every physician admitted to the hospital should be qualified for membership on the medical staff and assigned annually to one of the groups which the governing board may designate. These groups may include:

1. Honorary or consulting medical staff.
2. Attending or active medical staff.
3. Associate or courtesy medical staff.

Here again, officers should be elected annually, and the executive committee should assume supervision of the clinical work and act in an advisory capacity when medical matters are concerned. This type of medical staff organization is acceptable when the majority of its members are in general practice.

In the small hospital it is sometimes possible to establish clinical divisions of the medical staff. This tends to fix responsibility more definitely, stimulate scientific interest, and facilitate the administration of the professional services. Usually the clinical departments of medicine, surgery, obstetrics and gynecology, and eye, ear, nose, and throat may be organized. Each section should have a head or chief, or a staff committee responsible for the development and management of the service and for the supervision of all clinical work of the division. The organization of clinical departments presents a problem for each individual



hospital, either large or small, and in order that practical application may be made of the principle, care must be exercised to guard against departmentalization which exceeds the degree of local specialization.

A properly organized medical staff will not give advantages to any individual or group of physicians, or discriminate against the young physician properly qualified and competent, but will insure desirable supervision of all clinical work done in the institution.

There are many ways of promoting cooperation between the medical staff and the governing board. The most satisfactory plan, which has been accepted by hospitals generally, is the organization of a joint conference committee composed of duly selected members of the medical staff and the governing board which meets periodically to discuss problems of mutual concern. Some hospitals appoint a member of the medical staff to serve on the governing board, but this plan not only tends to create jealousy among the hospital's own conferees, but blights the interest of other members of the medical staff who have no connection with the administration of the hospital. There is always the possibility that the member of the medical staff who serves on the governing board will present personal opinions rather than voice the sentiment of the medical staff as a whole. For these reasons, therefore, a joint conference committee is to be preferred.

*Qualifications and appointment to the medical staff.*—The qualifications for membership on the medical staff, outlined in detail elsewhere in this text, are equally applicable to the small hospital, and it is needless to elaborate upon the principle which requires that membership on the medical staff of all hospitals be restricted to competent, experienced, ethical physicians and surgeons. The principles of hospital standardization emphasize the responsibility of the hospital management in selecting the medical staff and recommend a procedure to be followed in extending hospital privileges to physicians. Each physician should submit his qualifications in a written application, (see addendum V, pp. 104-105) and these should be investigated by a committee of the medical staff which should report to the medical staff as a whole with recommendations. If approved by the medical staff, the applicant is recommended to the governing board for membership in one of the medical staff divisions. It is considered advisable to extend hospital privileges for one year only, with the understanding that if the applicant's work and conduct have been satisfactory, further extension of privileges will be granted. This method saves the hospital embarrassment when occasionally mistakes occur in granting privileges to unworthy physicians.

The American College of Surgeons has laid down definite principles of financial relations in the professional care of the patient (see page 19) with which the medical staff of every approved hospital should comply. Each physician privileged to work in the approved hospital should subscribe to these principles when he becomes a member of the medical staff and lives up to them consistently.

*Bylaws, rules, and regulations.*—The first step in the organization of a medical staff is to formulate complete bylaws, rules, and regulations which set forth the type of organization and the duties, responsibilities, and procedures. They should be approved by the medical staff, signed by the chairman and secretary, and submitted to the governing board of the hospital for adoption. Since the governing board is responsible for the conduct of the hospital in all its activities, the bylaws, rules, and regulations should be officially adopted and attested by the signatures of the chairman and secretary of this board. Finally, the signatures of all members of the medical staff should be attached as evidence of good faith and of agreement to abide by the provisions adopted. Each hospital is expected to use its initiative in evolving rules which are applicable to its own needs. The American College of Surgeons has formulated and recommends the adoption of certain fundamental principles which should be included in all medical staff bylaws, rules, and regulations. For these suggestions reference is made to addendum I, pages 78 to 97, of this text.

*Medical staff conferences.*—One of the major requirements of the approved hospital is that medical-staff conferences be held at least once each month. This requirement may easily be met by the small hospital, for every institution caring for the sick and injured has a proportionate amount of interesting clinical material. The properly conducted medical-staff conference not only provides for a thorough review and analysis of the clinical work done in the institution, but constitutes more or less a postgraduate course in medicine. Every physician, regardless of his medical education, his training as an intern, and even his post-



graduate study, must continue to supplant and supplement his fund of medical knowledge. In many instances physicians practicing in the small communities have little opportunity for postgraduate study in the large, sometimes distant, medical centers because of time required and expense involved, but the medical staff conference can fulfill to a considerable degree this need for postgraduate education.

Attendance at medical staff conferences should never be less than 75 percent of the active medical staff. The attendance record of the individual member gives an excellent index of his interest in fulfilling his professional responsibility to the hospital. Good attendance at medical staff conferences, however, presupposes that an active committee of the medical staff has given its time and effort in the selection of material and the preparation of a program of interest.

Accurate minutes of all medical staff conferences should be prepared by the secretary of the medical staff; these should include not only the attendance record and reports of the various committees, but complete abstracts of all clinical cases should be presented and discussed. It is important that the minutes be prepared in an orderly fashion and kept on file in the hospital for reference and for review by the representative of the American College of Surgeons when he makes the regular survey of the hospital. His report relative to medical staff organization and proceedings is based primarily on the records of the secretary of the medical staff. (See addendum IV, p. 103.)

*Medical records.*—Every hospital, large or small, requires complete and acceptable medical records. In the small institution without interns or residents, the medical records may have to be written by the physicians themselves with whatever assistance the hospital can provide. The hospital may be too small to warrant a full time records librarian, but some person in the organization should undertake this work on a part time basis; it is well to assign the responsibility to one individual. The hospital may be able to employ on a part-time basis someone who can take medical dictation. Such a worker is a great aid to the physician and facilitates the keeping of adequate medical records. However, some hospitals in their efforts to provide medical records have resorted to the practice of allowing nurses or other nonmedical personnel to interview patients and write histories, progress notes, and other component parts, but these medical records are of uniformly poor quality and the practice should be discouraged. The procuring of adequate and complete medical records is wholly the responsibility of the attending physician and should always be under his direct supervision.

A medical records department constitutes a major problem in many small hospitals. Physicians frequently fail to realize their responsibility in these matters and the lack of a medical record consciousness on their part is regrettable. This lack of interest is generally due to failure to use the medical records properly after they are written, and although a medical record is of value to the patient primarily in that it assures him better service and more accurate diagnosis and treatment, it is also invaluable to the physician in the scientific practice of medicine.

The appointment of a member of the medical staff as medical records registrar, or of an active medical records committee, to review the medical records conscientiously and diligently, and see that they are kept up to a proper standard, is essential. Adequate medical records may be maintained in any hospital in which the proper record consciousness is developed on the part of the entire professional and lay personnel.

Medical records should be accessibly filed in a conveniently located record room, and should be regarded as the permanent property of the hospital, to be released only on order of the attending physician with the patient's consent or by order of a court. Numerical filing, either by admission or discharge number, is the most common method of filing medical records in hospitals at the present time. A complete cross-index system which will include separate indexes for patient, disease, operation, and physician may easily be provided, and to insure a uniform classification an acceptable nomenclature of disease should be adopted. This latter, and all of the required material for a cross-index system are inexpensive, and it has been found that an adequate, simple cross-index and filing system may be maintained by a part time records librarian devoting only a few hours each week to this work. The maintenance of a complete medical records department will then enable the medical staff properly to review, analyze, and evaluate collectively the clinical work done in the institution, and to use the medical records for scientific study.

*Clinical laboratory.*—The management of all hospitals should be responsible for providing an adequate clinical laboratory service. This should include a

small, practical clinical laboratory where the essential examinations, immediately necessary in assisting the clinician in making or confirming his diagnosis, may be made. These examinations include urinalysis, blood counts or examinations, coagulation time, smears, sputums, and spinal fluid cell counts. It is preferable that some blood chemistry be done, too, if competent technical service is available. The more elaborate examinations, such as tissue pathology, Widal's and Wassermann's tests, and other special procedures may be done in the larger laboratory in a nearby hospital or city. However, contact with the larger laboratory should always be made by the hospital management rather than by the individual physician, for it is only in this way that reports of examinations made will find their way to the files of the hospital.

Too much stress cannot be placed upon the importance of routine examination of all tissues removed at operation. Every piece of tissue should be sent to a qualified pathologist for gross or microscopic examination and report. For further elucidation or confirmation of the diagnosis a microscopic examination should be made of all tissues at the discretion of the pathologist. Investigation has shown that the larger accredited clinical laboratories are usually willing to cooperate with the small hospital in providing this necessary supplementary service at a cost that is not prohibitive, and certainly every patient in a modern hospital is entitled to this service.

In the small hospital some difficulty may be experienced in providing supervision and competent technical personnel for the clinical laboratory. Each hospital offers an individual problem which in most instances can readily be solved. It is desirable, if at all possible, for the hospital to have the part-time services of a well-trained clinical pathologist. Oftentimes arrangements can be made for a pathologist to serve two or more hospitals—provided that each has a competent technical staff. He can make rounds at regular intervals to examine tissues, carry out special tests, and supervise the work of the department. When feasible, the visiting pathologist should arrange to attend the meetings of the medical staff for by actively entering into the clinical discussions, he is able, because of his scientific interest, to exert a great influence on the practice of medicine in the community.

In some instances it is practical only to have a member of the medical staff who has had fundamental training in clinical laboratory work supervise the activities of the clinical laboratory. Obviously, when a member of the medical staff assumes this supervision, arrangements should be made with a competent pathologist in a nearby city. In the best interests of the institution and the community the selected physician should pursue all possible means of increasing his knowledge of clinical pathology. The consulting pathologist should visit the hospital periodically and be called when unusual problems arise in the department.

The laboratory technician must have training and experience sufficient to insure the hospital management and medical staff that she is competent to do the work assigned to her. She should be a registered technician or one who has successfully passed her qualifying board. Frequently one technician can be trained to handle the work in both the clinical laboratory and X-ray department. If this is not feasible, possibly a graduate nurse who has had the necessary training and experience can take charge of this work along with her other duties. A member of the medical staff may volunteer to do the technical work until the hospital can make more suitable arrangements. However, every instance will require individual consideration in planning the laboratory service of the small hospital.

There have been no arbitrary regulations adopted relative to details of keeping clinical laboratory records. However, all reports of findings should be filed in the department and cross-indexed, including reports of work sent out to the larger hospital laboratories. Duplicate reports should be made of all laboratory procedures, to become a permanent part of the patient's medical record.

*X-ray department.*—Every hospital should have at least a portable X-ray unit for an emergency service, particularly for the nonambulatory patient. The ambulatory patient may be sent to the X-ray department in the nearest large hospital. It is desirable, however, for each small hospital to maintain sufficient equipment for radiographic and fluoroscopic X-ray work.

Competent supervision of technical personnel is also essential in the X-ray department, and a part-time radiologist who will periodically visit the hospital and make the necessary interpretations of X-ray films is to be preferred. If this is not possible, a member of the medical staff with fundamental training



in radiology and particularly interested in the field may be assigned to supervise this service. In the latter case, a competent consulting radiologist in a nearby city should be engaged and called upon to assist in interpreting obscure findings. In all instances the department should have medical supervision, for the responsibility of interpreting the X-ray films constitutes medical roentgenology—a branch of medicine—and is the work of a physician. A satisfactory technical service may usually be arranged by combining the duties of a properly trained technician with other work in the hospital, such as clinical laboratory technician, anesthetist, medical records librarian, or others.

A written report of the interpretation of all X-ray films and treatments should be properly signed by the radiologist and retained in the files of the department, reports being cross-indexed according to the pathology described. A duplicate of all X-ray reports should be attached to the patient's chart to become a permanent part of the medical record. Adequate provision is essential for the filing and storage of X-ray films in fireproof cabinets or vaults, where it is generally agreed that they should remain as the permanent property of the hospital. Roentgenograms are a part of the patient's hospital record and should not be removed from the hospital unless subpoenaed by a court and accompanied by an authorized representative of the hospital.

*Summary.*—The American College of Surgeons urges that each small hospital organize a medical staff, maintain adequate medical records, and hold regular staff conferences that they may avail themselves of the best possible clinical diagnostic services. The extent of organization and service will, of course, depend upon the hospital location and environment. It is not intended that hospital standardization shall work a hardship on any hospital; in fact, in most instances improved facilities and properly organized departments enable the small hospital to gain further public confidence and thus to retain in the community an increasing number of patients who otherwise would find their way into the larger city institutions. Hospital standardization has therefore provided for the growth and progress of the small hospital which has adopted the principles of the minimum standard for hospitals and applied them in an acceptable manner.

#### ADDENDUM I. BYLAWS, RULES, AND REGULATIONS FOR MEDICAL STAFFS AS APPROVED BY THE AMERICAN COLLEGE OF SURGEONS

From the point of view of organization of the medical staff it is found that hospitals may be divided into four types. Hospitals of types I, II, and III are owned by governmental bodies, communities, church organizations, fraternal organizations, or joint stock companies. They are organized not for profit, and may admit free, part pay, and pay patients. Free patients are attended by the active medical staff; pay patients are usually referred by their own physician and are attended by him. Some pay patients who have no attending physician will apply for admission and they must be assigned to physicians by the hospital. Type IV hospital is privately owned, either by a partnership which may be lay or medical, or by an industrial corporation. It is organized for profit and admits only pay patients.

##### TYPE I HOSPITAL, 50 BEDS OR LESS

The hospital is owned by a church, fraternal organization, the community, or a joint stock company. It is organized not for profit and admits free, part pay, and pay patients. Free patients are attended by the active medical staff; pay patients are usually referred by their own physician and are attended by him. Some pay patients will apply for admission who have no attending physician and must be assigned by the hospital.

The hospital is usually of 50 beds or less. Its medical staff is comprised of local physicians and those from neighboring communities who are permitted to attend pay patients. Only a limited departmentalization is possible.

It is desirable to control the work of the medical staff, limiting each member to that which his training and experience have made him capable of carrying on successfully. Provision for adequate control may be made by selecting those parts of the bylaws for a hospital of type II which are applicable, and adapting them to the needs and possibilities of the smaller hospital.

Each hospital must use its initiative in formulating bylaws, rules, and regulations which are applicable to its own needs. Those portions of the following sample bylaws, rules, and regulations in the suggested form which do not pertain



to a given hospital or which cannot become operable within the institution should be modified. There are, however, a number of major principles which are fundamental and which should be embodied in all medical staff bylaws, rules, and regulations in order to comply with the minimum requirements of Hospital Standardization. These are outlined under "Clause III of the Minimum Standard for Hospitals" (pp. 21 and 22).

Since the governing board is responsible for the conduct of the hospital, the bylaws, rules, and regulations should be officially adopted and attested by the signatures of its chairman and secretary in order to make the document effective. Finally, the signatures of all members of the medical staff should be affixed as evidence of good faith and agreement to abide thereby. In order to prevent the bylaws from becoming antiquated and disregarded, they should be revised every 3 to 5 years by a committee of the medical staff and the director of the hospital, approved by the governing board, and a copy placed in the minute book of the medical staff proceedings for ready reference.

### *Bylaws Preamble*

Recognizing that the best interests of the patient are protected by concerted effort, the physicians practicing in \_\_\_\_\_ Hospital hereby organize themselves in conformity with the bylaws, rules, and regulations herein-after stated.

For the purpose of these bylaws the word medical staff shall be interpreted to include all physicians who are privileged to attend patients in \_\_\_\_\_ Hospital.

Whenever the term governing board appears, it shall be interpreted to refer to the board of directors, the board of trustees, the board of managers, or other controlling group.

### *Article I. Name*

The name of this organization shall be the "Medical Staff of \_\_\_\_\_ Hospital."

### *Article II. Purpose*

The purpose of the organization shall be:

1. To insure that all patients admitted to the hospital or treated in the out-patient department receive the best possible care.
2. To provide a means whereby problems of a medico-administrative nature may be discussed by the medical staff with the governing board and the administration.
3. To initiate and maintain self-government.
4. To provide education and to maintain educational standards.

### *Article III. Membership*

#### **Section 1. Qualifications**

The applicant for membership on the medical staff shall be a graduate of an approved medical school, legally licensed to practice in the State (or province) of \_\_\_\_\_ qualified for membership in the local medical society, and practicing in the community or within reasonable distance of the hospital.

#### **Section 2. Ethics and Ethical Relationships**

The code of ethics as adopted by the American Medical Association and the "Principle of Financial Relations in the Professional Care of the Patient" of the American College of Surgeons shall govern the professional conduct of the members of the medical staff. Specifically, all members of the medical staff shall pledge themselves that they will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services. On the contrary it shall be agreed that all fees shall be collected and retained by the individual physician in accordance with the value of services rendered.

#### **Section 3. Application for Membership**

Application for membership on the medical staff shall be presented in writing, on the prescribed form, which shall state the qualifications and references of the applicant, and shall also signify his agreement to abide by the bylaws, rules, and regulations of the medical staff.

#### Section 4. Terms of Appointment

(a) Appointments to the medical staff shall be made by the governing board of the hospital and shall be for the period of 1 year or until the end of the fiscal year of the hospital. At the end of the fiscal year the governing board of the hospital may reappoint all members of the medical staff for a further period of 1 year, provided the medical staff has not recommended that any specific appointment shall not be renewed. In such case all other reappointments may be made.

(b) Should the governing board wish to take the initiative in refusing to make reappointment of any member, it shall so advise the medical staff, stating reasons and asking for recommendations as to further action.

(c) In no case shall the governing board take action on an application, refuse to renew an appointment, or cancel an appointment previously made without conference with the medical staff.

(d) Appointment to the medical staff shall confer on the appointee only such privileges as may be hereinafter provided.

#### Section 5. Procedure for Appointment

(a) The application for membership on the medical staff shall be presented to the director of the hospital and by him referred to the secretary of the medical staff.

(b) At the first regular meeting thereafter, the secretary shall present the application to the medical staff, at which time it shall be either rejected or referred to the credentials committee.

(c) The credentials committee shall investigate the character, qualifications, and standing of the applicant and shall submit a report of findings at the next regular meeting of the medical staff, or as soon thereafter as possible, recommending that the application be accepted, deferred, or rejected. In no case shall this report be delayed for more than 3 months.

(d) On receipt of the report of the credentials committee, the medical staff shall recommend to the governing board that the application be accepted, deferred, or rejected.

(e) The recommendation of the medical staff shall be transmitted to the governing board through the director of the hospital.

(f) The governing board shall either accept the recommendation of the medical staff or shall refer it back for further consideration. In the latter case the governing board shall instruct its secretary to state to the medical staff the reasons for such action.

(g) When final action has been taken by the governing board, the director of the hospital shall be authorized to transmit this decision to the candidate for membership, and if he is accepted, to secure his signature to the bylaws, rules, and regulations. Such signature shall constitute his agreement to be governed by the said bylaws, rules, and regulations.

#### Section 6. Emergency and Temporary Privileges

(a) In case of emergency, the physician attending the patient shall be expected to do all in his power to save the life of the patient, including the calling of such consultation as may be available. For the purpose of this section, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would add to that danger.

(b) The director of the hospital shall have the authority to grant temporary privileges to a physician who is a member of the local medical society and desires to attend an occasional patient in the hospital but who is not a member of the medical staff. Such temporary privileges shall be granted after conference with the chief of staff to determine an authoritative opinion as to the competence and ethical standing of the physician who desires such temporary privileges, and in the exercise of such privileges he shall be under direct supervision of the chief of staff. Temporary privileges may not be granted to attend more than four patients in any 1 year, after which the physician to whom temporary privileges have been granted shall be required to become a member of the medical staff before being allowed to attend additional patients.

#### Article IV. Divisions of the Medical Staff

##### Section I. The Medical Staff

The medical staff shall be divided into honorary, consulting, active, associate, and courtesy groups.

### Section 2. The Honorary Medical Staff

The honorary medical staff shall consist of physicians who are not active in the hospital and who are honored by emeritus positions. These may be physicians who have retired from active hospital service or physicians of outstanding reputation.

The honorary medical staff shall be appointed by the governing board on recommendation of the active medical staff and shall have no assigned duties or responsibilities.

### Section 3. The Consulting Medical Staff

(a) The consulting medical staff shall consist of recognized specialists who are active in the hospital or who have signified willingness to accept such appointment. These may be fellows of the American College of Surgeons or the American College of Physicians, diplomates of one of the national boards of medical specialties, members of the national society representing the specialty, or others whom the credentials committee may consider to be worthy of being appointed as members of the consulting staff. Membership on the consulting staff shall not render the member ineligible for membership on the active staff.

(b) Appointment shall be made by the governing board on recommendation of the active medical staff. Credentials shall not be required for such appointments and the proposed member may be invited to accept appointment.

(c) The duties of the members of the consulting medical staff shall be to give their services, without charge, in the care of free patients on request of any member of the active medical staff, and also in any case in which consultation is required by the rules of the hospital.

### Section 4. The Active Medical Staff

(a) The active medical staff shall consist of physicians who are resident in the community and are both willing and able to devote their time to the interests of the hospital. Members of the active medical staff shall not be required to be exclusive specialists, but it is to be expected that they will be well skilled in the particular branch of medicine to which they are assigned, and that a large portion of their private practice will fall within that specialty.

(b) Appointments shall be made annually by the governing board on recommendation of the active medical staff. Former members of the active medical staff may be reappointed and, in so far as it is possible, new appointees shall have been members of the courtesy medical staff.

(c) The duties of the active medical staff shall be to attend free patients when such patients are admitted and to transact all business of the medical staff. Only members of the active medical staff shall be eligible to vote or hold office.

### Section 5. The Courtesy Medical Staff

The courtesy medical staff shall consist of those members of the medical profession, eligible as herein provided for medical-staff membership, who wish to attend private patients in the hospital, but who do not wish to become members of the active medical staff or who, by reason of residence, are not eligible for such appointment. They shall be appointed in the same manner as other members of the medical staff and they shall have the privilege of attending private patients, but they shall not be eligible to vote or hold office. They shall have no assigned duties.

## *Article V. Clinical Departments*

### Section I. Services

The active medical staff shall be divided into medical, surgical, and such other services as the size and degree of specialization of the active medical staff may warrant.

### Section 2. Assignment to Services

Assignment to the different services shall be made by the active medical staff at its first meeting after its membership has been appointed by the governing board and members shall remain on service for 1 year or until a successor has been appointed.



### Section 3. Organization of Services

Immediately after assignment has been made the members of each service shall meet and shall organize in such a manner as to insure proper care of free patients.

#### *Article VI. Officers and Committees*

##### Section I. Officers

The officers of the medical staff shall be the president, the vice president, and the secretary. These shall be elected at the annual meeting of the medical staff, and shall hold office until the next annual meeting or until a successor is elected.

The President, who shall also be the chief of the medical staff, shall call and preside at all meetings, shall be a member ex officio of all committees, and shall have general supervision over all of the professional work of the hospital.

The vice president in the absence of the president shall assume all his duties and have all his authority. He shall also be expected to perform such duties of supervision as may be assigned to him by the president.

The secretary shall keep accurate and complete minutes of all meetings, call meetings on order of the president, attend to all correspondence, and perform such other duties as ordinarily pertain to his office. If there are funds to be accounted for, he shall also act as treasurer.

##### Section 2. Committees

Committees of the medical staff shall be standing and special. All committees other than the executive shall be appointed by the president. (In the very small hospital having only a few members on its medical staff it may be advisable to have the entire staff act as a committee of the whole for the transaction of business, delegating specific duties such as supervision of medical records to individual members.)

The executive committee shall consist of the president and secretary of the medical staff and of three other members of the active medical staff to be elected at the time of the annual meeting. The duties of the executive committee shall be to consider carefully and act on all matters which are not of a clinical nature and it is to be expected that all such business of the medical staff shall be transacted by the executive committee in order that the time of the regular meetings of the medical staff may be devoted to matters pertaining to the professional care of patients. The executive committee shall present, at each meeting of the medical staff, a report of any action that it may have taken since the last meeting. The executive committee shall act as a liaison group between the medical staff and the administration of the hospital.

The medical records committee shall consist of three members of the medical staff and shall meet weekly for the purpose of reviewing the medical records of all patients discharged during the week. The committee shall report to the medical staff the names of any members who are persistently delinquent in the completion of their records. It shall also act as a program committee and be responsible for the preparation and presentation of all programs.

The credentials committee shall consist of three members of the active medical staff. Its duties shall be to investigate the credentials of all applicants for membership and to make recommendations in conformity with article III, section 5 (c) of these bylaws.

The intern committee shall consist of three members of the medical staff. Its duties shall be to act as an advisory committee in the selection of interns, to outline courses of instruction for the resident medical staff and to see that they are carried out, and to assist the administration in matters of government and discipline of the resident medical staff.

Special committees shall be appointed from time to time as may be required to carry out properly the duties of the medical staff. Such committees shall confine their work to the purposes for which they were appointed and shall report to the full medical staff. They shall not have power of action unless such is specifically granted by the motion which created the committee.

*Article VII. Meetings***Section I. The Annual Meeting**

The annual meeting of the medical staff shall be the last meeting before the end of the fiscal year of the hospital. At this meeting the retiring officers and committees shall make such reports as may be desirable, officers for the ensuing year shall be elected, and recommendations for appointment to the active medical staff shall be made.

**Section 2. Regular Meetings**

Regular meetings of the medical staff shall be held at least monthly at a time and place to be provided in the rules and regulations for the government of the medical staff.

**Section 3. Special Meetings**

Special meetings of the medical staff may be called at any time by the president and shall be called at the request of any five members of the active medical staff.

**Section 4. Attendance at Meetings**

(a.) Members of the active medical staff shall be required to attend all meetings. Absence from three consecutive meetings or from one-third of the regular meetings for the year, without acceptable excuse, shall be considered as resignation from the active medical staff, and shall automatically place the absentee on the courtesy medical staff of the hospital.

(b.) Reinstatement of members of the active medical staff to positions rendered vacant because of absence from meetings may be made on application, the procedure being the same as in the case of original appointment.

(c.) Members of the honorary, consulting, and courtesy divisions of the medical staff shall not be required to attend meetings, but it is expected that they will attend and participate in these meetings unless they are unavoidably prevented from doing so.

(d.) A member of any division of the medical staff who has attended a case that is to be presented for discussion at any meeting shall be notified and required to be present.

Failure to attend on receipt of such notice shall involve the penalty, in the case of a member of the consulting or active medical staff, of reverting to the courtesy medical staff and, in the case of a member of the courtesy medical staff, of forfeiting his medical staff membership.

(e.) Should a member of the medical staff be absent from any meeting at which a case that he has attended is to be presented, it shall be discussed nevertheless unless the member is unavoidably absent and has requested postponement of the discussion. In no case shall such postponement be granted for a period longer than that which will elapse until the next regular medical staff meeting.

**Section 5. Quorum**

Fifty percent of the total membership of the active medical staff shall constitute a quorum.

**Section 6. Agenda**

The agenda at any regular meeting shall be:

**A. Business:**

1. Call to order.
2. Reading of the minutes of the last regular and of all special meetings.
3. Unfinished business.
4. Communications.
5. Reports of standing and of special business committees.
6. New business.

**B. Medical:**

7. Review of patients in the hospital with special reference to diagnoses, treatment, and delayed recovery; selected cases discharged since the last conference with special consideration of selected deaths, unimproved cases, infections, complications, errors in diagnoses, and results of treatment; and analysis of clinical reports from the various departments.

8. Reports of standing and of special medical staff committees.
9. Discussion and recommendations for improvement of the professional work of the hospital.
10. Adjournment.

The agenda at special meetings shall be:

1. Reading of the notice calling the meeting.
2. Discussion of the business for which the meeting was called.
3. Adjournment.

#### *Article VIII. Rules and Regulations*

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these bylaws, except that they may be amended at any regular meeting without previous notice by a two-thirds vote of the total membership of the active medical staff. Such amendments shall become effective when approved by the governing board.

#### *Article IX. Amendments*

These bylaws may be amended after notice given at any regular meeting of the active medical staff. Such notice shall be laid on the table until the next regular meeting and a two-thirds majority of those present shall be required for adoption. Amendments so made shall be effective when approved by the governing board.

#### *Article X. Adoption*

These bylaws shall be adopted at any regular meeting of the active medical staff and shall become effective when approved by the governing board of the hospital. They shall, when adopted and approved, be equally binding on the governing board and the medical staff.

Adopted by the active medical staff of \_\_\_\_\_ Hospital.

\_\_\_\_\_  
President of medical staff

\_\_\_\_\_  
Secretary of medical staff

Date \_\_\_\_\_

Approved by the governing board of \_\_\_\_\_ Hospital.

\_\_\_\_\_  
Secretary of the governing board

Date \_\_\_\_\_

#### *Rules and Regulations*

1. The monthly meeting of the medical staff shall be held \_\_\_\_\_  
2. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the director secured. In case of emergency the provisional diagnosis shall be stated as soon after admission as possible.

3. Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever.

4. All free patients shall be attended by members of the active medical staff, and shall be assigned to the service concerned in the treatment of the disease which necessitated admission or in rotation if there is no service division. No physician shall receive any compensation for attendance in the case of any patient who is admitted free by the hospital. Pay patients shall be attended by their own private physicians. In the case of a pay patient applying for admission who has no attending physician, he shall be assigned in rotation to the members of the active medical staff on duty in the service to which the illness of the patient indicates assignment.

5. Laboratories shall be provided in the hospital to insure as complete a service as possible. Examinations which cannot be made in the hospital shall be referred to an outside approved laboratory and in the case of pay patients will be charged to the patient at cost.

Standing orders shall be formulated by conference between the medical staff and the director of the hospital. They may be changed only by the director after conference with the medical staff. These orders shall be followed insofar as



proper treatment of the patient will allow, and when specific orders are not written by the attending physician they shall constitute the orders for treatment.

7. All orders for treatment shall be in writing. Verbal orders shall not be accepted or carried out. An order shall be considered to be in writing if dictated to a senior nurse or other authorized person and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his or her own name. At his next visit the attending physician shall sign such orders.

8. As far as possible the use of proprietary remedies shall be avoided. When such are ordered for private patients by the attending physician, they will be secured and a special charge made to the patient.

9. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultation, clinical laboratory, X-ray, and others; provisional diagnosis, medical or surgical treatment, pathological findings, progress notes, final diagnosis, condition on discharge, follow-up, and autopsy report when available. No medical record shall be filed until it is complete except on order of the medical records committee.

10. A complete history and physical examination in all cases shall be written within 24 hours after admission.

11. When such history and physical examination are not recorded before the time stated for operation, the operation shall be canceled, unless the attending surgeon states in writing that such delay would be detrimental to the patient.

12. All records are the property of the hospital and shall not be taken away without permission. In case of readmission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient be free or pay; and whether he be attended by the same physician or by another.

13. Except in cases of emergency, patients for operation shall be admitted not later than 4 o'clock the day previous to operation.

14. All operations performed shall be fully described by the attending surgeon. All tissues removed at operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

15. In all cases where a patient is admitted in a condition of abortion, she or her representative shall sign a statement certifying that neither any employee of the hospital nor the attending physician was directly or indirectly responsible for its production.

16. Except in emergency, consultation with a member of the consulting or of the active medical staff shall be required in all major cases in which the patient is not a good risk and in all curettages or other operations which may interrupt a known, suspected, or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case. In all cases where a rule of the hospital requires consultation and in the case of free patients, the consultant shall give his services without charge.

17. Each member of the courtesy medical staff, not resident in the city, or immediate vicinity, shall name a member of the medical staff who is resident in the city, who may be called to attend his patients in emergency. In case of failure to name such associate, the director of the hospital shall have authority to call any member of the staff should he consider it necessary.

18. Patients shall be discharged only on written order of the attending physician. At the time of discharge the attending physician shall see that the record is complete, state his final diagnosis, and sign the record.

19. At the monthly meeting of the medical staff the medical records librarian shall submit a report of the professional work of the hospital for the previous month. This shall show patients discharged and the results, deaths (the cause being stated as given by the attending physician), autopsies, consultations, and infections of all kinds. The discussion at the meeting shall be based on this report and at no meeting shall abstract discussion of scientific medical subjects be permitted. After each meeting the secretary of the medical staff shall transmit to the director of the hospital such reports and recommendations as the medical staff may wish to make to him or through him to the governing board.

20. Every member of the medical staff shall be actively interested in securing autopsies whenever possible. No autopsy shall be performed without written

consent of a responsible relative or friend. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty.

21. The hospital shall admit patients suffering from all types of disease except the following: (Specify diseases not treated). Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the medical staff.

Adopted at a regular meeting of the active medical staff.

-----  
President of the medical staff

-----  
Secretary of medical staff

Date -----

Approved by the governing board.

-----  
Secretary of the governing board

Date -----

#### TYPE II HOSPITAL (50 TO 100 BEDS)

The hospital is owned by a church, fraternal organization, the community, or a joint stock company. It is organized not for profit and admits free, part pay, and pay patients. Free patients are attended by the active medical staff; pay patients are usually referred by their own physician and are attended by him. Some pay patients will apply for admission who have no attending physician and must be assigned by the hospital.

The hospital is usually one of from 50 to 150 beds. Its medical staff is comprised of local physicians and those from neighboring communities who are permitted to attend pay patients, but there is some specialization and as a result there is a certain amount of departmentalization.

Each hospital must use its initiative in formulating bylaws, rules, and regulations which are applicable to its own needs. Those portions of the following sample bylaws, rules, and regulations in the suggested form which do not pertain to a given hospital or which cannot become operable within the institution should be modified. There are, however, a number of major principles which are fundamental and which should be embodied in all medical staff bylaws, rules, and regulations in order to comply with the minimum requirements of hospital standardization. These are outlined under clause III of the Minimum Standard for Hospitals (pp. 21 and 22).

Since the governing board is responsible for the conduct of the hospital, the bylaws, rules, and regulations should be officially adopted and attested by the signatures of its chairman and secretary in order to make the document effective. Finally, the signatures of all members of the medical staff should be affixed as evidence of good faith and agreement to abide thereby. In order to prevent the bylaws from becoming antiquated and disregarded, they should be revised every 3 to 5 years by a committee of the medical staff and the director of the hospital, approved by the governing board, and a copy placed in the minute book of the medical staff proceedings for ready reference.

#### *Bylaws Preamble*

Recognizing that the best interests of the patient are protected by concerted effort, the physicians practicing in ----- Hospital hereby organize themselves in conformity with the bylaws, rules, and regulations hereinafter stated.

For the purpose of these bylaws the words "medical staff" shall be interpreted to include all physicians who are privileged to attend patients in ----- Hospital.

Whenever the term "governing board" appears, it shall be interpreted to refer to the board of directors, the board of trustees, the board of managers, or other controlling group.

#### *Article I. Name*

The name of this organization shall be the medical staff of ----- Hospital.

*Article II. Purpose*

The purpose of the organization shall be—

1. To insure that all patients admitted to the hospitals or treated in the out-patient department receive the best possible care.
2. To provide a means whereby problems of a medico-administrative nature may be discussed by the medical staff with the governing board and the administration.
3. To initiate and maintain self-government.
4. To provide education and to maintain educational standards.

*Article III. Membership**Section 1. Qualifications*

The applicant for membership on the medical staff shall be a graduate of an approved medical school, legally licensed to practice in the State (or Province) of \_\_\_\_\_, qualified for membership in the local medical society, and practicing in the community or within reasonable distance of the hospital.

*Section 2. Ethics and Ethical Relationships*

The code of ethics as adopted by the American Medical Association and the Principles of Financial Relations in the Professional Care of the Patient of the American College of Surgeons shall govern the professional conduct of the members of the medical staff. Specifically, all members of the medical staff shall pledge themselves that they will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services. On the contrary it shall be agreed that all fees shall be collected and retained by the individual physician in accordance with the value of services rendered.

*Section 3. Application for Membership*

Application for membership on the medical staff shall be presented in writing, on the prescribed form, which shall state the qualifications and references of the applicant, and shall also signify his agreement to abide by the bylaws, rules, and regulations of the medical staff.

*Section 4. Terms of Appointment*

(a) Appointments to the medical staff shall be made by the governing board of the hospital and shall be for the period of 1 year or until the end of the fiscal year of the hospital. At the end of the fiscal year the governing board of the hospital may reappoint all members of the medical staff for a further period of 1 year, provided the medical staff has not recommended that any specific appointment shall not be renewed. In such case all other reappointments may be made.

(b) Should the governing board wish to take the initiative in refusing to make reappointment of any member, it shall so advise the medical staff, stating reasons and asking for recommendations as to further action.

(c) In no case shall the governing board take action on an application, refuse to renew an appointment, or cancel an appointment previously made without conference with the medical staff.

(d) Appointment to the medical staff shall confer on the appointee only such privileges as may be hereinafter provided.

*Section 5. Procedure for Appointment*

(a) The application for membership on the medical staff shall be presented to the director of the hospital and by him referred to the secretary of the medical staff.

(b) At the first regular meeting thereafter, the secretary shall present the application to the medical staff, at which time it shall be either rejected or referred to the credentials committee.

(c) The credentials committee shall investigate the character, qualifications, and standing of the applicant and shall submit a report of findings at the regular



meeting of the medical staff, or as soon thereafter as possible, recommending that the application be accepted, deferred, or rejected. In no case shall this report be delayed for more than 3 months.

(d) When determining qualifications, the credentials committee shall also assign privileges as provided in article VI, sections 1 and 2 of these bylaws.

(e) On receipt of the report of the credentials committee, the medical staff shall recommend to the governing board that the application be accepted, deferred, or rejected.

(f) The recommendation of the medical staff shall be transmitted to the governing board through the director of the hospital.

(g) The governing board shall either accept the recommendation of the medical staff or shall refer it back for further consideration. In the latter case the governing board shall instruct its secretary to state to the medical staff the reasons for such action.

(h) When the final action has been taken by the governing board, the director of the hospital shall be authorized to transmit this decision to the candidate for membership, and if he is accepted, to secure his signature to these bylaws, rules, and regulations. Such signature shall constitute his agreement to be governed by the said bylaws, rules, and regulations.

### Section 6. Emergency and Temporary Privileges

(a) In case of emergency, the physician attending the patients shall be expected to do all in his power to save the life of the patient, including the calling of such consultation as may be quickly available. For the purpose of this section, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would add to that danger.

(b) The directors of the hospital shall have the authority to grant temporary privileges to a physician who is a member of the local medical society and desires to attend an occasional patient in the hospital but who is not a member of the medical staff. Such temporary privileges shall be granted after conference with the chief of staff to determine an authoritative opinion as to the competence and ethical standing of the physician who desires such temporary privileges, and in the exercise of such privileges he shall be under direct supervision of the chief of staff. Temporary privileges may not be granted to attend more than four patients in any one year, after which the physician to whom temporary privileges have been granted shall be required to become a member of the medical staff before being allowed to attend additional patients.

### Article IV. Divisions of the medical staff

#### Section 1. The Medical Staff

The medical staff shall be divided into honorary, consulting, active, associate, and courtesy groups.

#### Section. 2. The Honorary Medical Staff

The honorary medical staff shall consist of physicians who are not active in the hospital and who are honored by emeritus positions. These may be physicians who have retired from active hospital service or physicians of outstanding reputation.

The honorary medical staff shall be appointed by the governing board on recommendation of the active medical staff and shall have no assigned duties or responsibilities. Their privileges shall be determined by the credentials committee as provided in article VI of these bylaws.

#### Section 3. The Consulting Medical Staff

(a) The consulting medical staff shall consist of recognized specialists who are active in the hospital or who have signified willingness to accept such appointment. These may be Fellows of the American College of Surgeons or the American College of Physicians, diplomates of one of the national boards of medical specialties, members of the national society representing the specialty, or others whom the credentials committee may consider to be worthy of being appointed as members of the consulting staff. Membership on the consulting staff shall not render the member ineligible for membership on the active staff.

(b) Appointment shall be made by the governing board on recommendation of the active medical staff. Credentials shall not be required for such appointments and the proposed member may be invited to accept appointment.

(c) The duties of the members of the consulting medical staff shall be to give their services without charge in the care of free patients on request of any member of the active medical staff, and also in any case in which consultation is required by the rules of the hospital.

(d) Insofar as their specialty is concerned, members of the consulting medical staff shall have unrestricted privileges, but in cases not falling within their specialty they shall have such privileges as may be determined by the credentials committee as provided in article VI of these bylaws.

#### Section 4. The Active Medical Staff

(a) The active medical staff shall consist of physicians, resident in the community, who have been selected to attend free patients in the hospital and to whom all such patients shall be assigned. Members of the active medical staff shall not be required to be exclusive specialists, but it is to be expected that they will be well skilled in the particular branch of medicine to which they are assigned, and that a large proportion of their private practice will fall within that specialty.

(b) Appointments shall be made annually by the governing board on recommendation of the active medical staff from the former members of the active medical staff and, insofar as it is possible, vacancies shall be filled by promotion of members of the associate medical staff.

(c) The duties of the active medical staff shall be to attend free patients and, insofar as free work is concerned, they shall attend only such patients as are admitted to the service to which they are assigned. All business of the medical staff shall be transacted by the active medical staff and only members of the active medical staff shall be eligible to vote or hold office.

(d) Insofar as free cases are concerned, the members of the active medical staff shall have unrestricted privileges and shall treat patients assigned to their services to a conclusion regardless of whether this treatment is carried on in the in- or out-patient department. Insofar as private cases are concerned, they shall have unrestricted privileges in the treatment of patients falling within the specialty to which they are appointed, but in others they shall have only such privileges as may be determined by the credentials committee in conformity with article VI of these bylaws.

#### Section 5. The Associate Medical Staff

(a) The associate medical staff shall consist of junior members of the medical staff or of physicians who have not been actively interested in the work of the hospital but have expressed a wish to become active as vacancies occur.

(b) They shall be appointed and assigned to services in the same manner as members of the active medical staff and each shall be associated with a member of the active medical staff.

(c) The duties of the members of the associate medical staff shall be to attend free patients in accordance with assignment by the senior with whom they are associated. They may be required also to act on all committees except the executive committee and the credentials committee.

(d) Insofar as free cases are concerned, they shall be limited to the treatment of cases falling within their service in accordance with assignment by their senior. Insofar as private patients are concerned, they shall have such privileges as may be determined by the credentials committee in conformity with article VI of these bylaws.

#### Section 6. The Courtesy Medical Staff

The courtesy medical staff shall consist of those members of the medical profession, eligible as herein provided for medical staff membership, who wish to attend private patients in the hospital, but who do not wish to become members of the active medical staff or who, by reason of residence, are not eligible for such appointment. They shall be appointed in the same manner as other members of the medical staff and they shall have such privileges as may be determined by the credentials committee in conformity with article VI of these bylaws but they shall not be eligible to vote or hold office.

*Article V. Clinical Departments*

## Section 1. Services

The active medical staff shall be divided into medical, surgical, and such other services as the size and degree of specialization of the active medical staff may warrant.

## Section 2. Assignment to Services

Assignment to the different services shall be made by the active medical staff at its first meeting after its membership has been appointed by the governing board and members shall remain on service for 1 year or until a successor has been appointed.

## Section 3. Organization of Services

Immediately after assignment has been made the members of each service shall meet and shall organize in such a manner as to insure proper care of free patients.

*Article VI. Determination of Qualifications and Privileges*

## Section 1. Classification of Privileges

Privileges extended to physicians who have been appointed to the medical staff shall be divided into major, intermediate, and minor, and shall be determined by the credentials committee. The following shall serve as a guide in differentiating the three types of privileges:

(a) Major privileges in any service will allow the physician to treat patients when, for any cause, such treatment involves a serious hazard to the life of the patient.

(b) Intermediate privileges in any service will allow the physician to treat patients when, for any cause, such treatment does not involve a serious hazard to the life of the patient but does involve a danger of disability.

(c) Minor privileges in any service will allow the physician to treat patients when, for any cause, the treatment does not involve either a serious hazard to the life of the patient or a danger of disability.

## Section 2. Newly Appointed Medical Staff Members

All members of the medical staff when newly appointed shall be granted only minor privileges until such time as the credentials committee shall determine what further privileges may be granted with safety to the patient, such extension of privileges being based, as far as possible, on records of performance as provided in sections 3 and 4 of this article.

## Section 3. Professional Service Accounting

A system of professional service accounting shall be maintained under which records of performance of each member of the medical staff shall be available.

(a) On or immediately after admission of the patient the attending physician shall classify the treatment proposed, in conformity with the pathology found, under one of the following prognostic categories:

<i>Elective</i>	<i>Emergency</i>	<i>Palliative</i>
1. Good	4. Good	7. Good
2. Fair	5. Fair	8. Fair
3. Bad	6. Bad	9. Bad

Should the attending physician consider the risk to be fair or bad in any of the categories or should he subsequently desire to change his prognosis, he shall be required to state his reasons. At the time of discharge, the immediate result shall be stated as recovered or died.

(b) The professional service accounting shall be administered by a professional service accountant, appointed by the administration with the advice of the medical staff, whose duty it shall be to check the prognosis and statement of result to determine whether they are correctly stated; to determine whether the result is such as may be reasonably expected from the prognosis and, if not, whether the result is justified or inevitable; and to determine any errors that may be apparent as evidenced by the medical record.



(c) In cases in which the professional service accountant does not feel competent to pass judgment or in which there may be reason for discussion, the record shall be referred to the credentials committee who may exercise judgment or refer the case to the active medical staff for discussion and decision.

(d) The decision of the professional service accountant, of the credentials committee, or of the active medical staff, as the case may be, shall be attached as a memorandum to the medical record. This memorandum shall not be preserved as a part of the medical record.

(e) The medical records librarian shall keep a record of the performance of each physician, and she shall enter the decisions and remarks as above provided, except that no record of errors shall be kept after the medical staff has taken appropriate action. This record shall be kept confidential and shall be accessible only to the credentials committee when determining the recommendations which it will make for promotion and appointment to the various services, except that any member of the medical staff desiring information as to his own performance may have access to his own section of the record at any time. After all entries for the year have been made, the various columns shall be totaled.

#### Section 4. Direct Observation

Every member of the consulting or active medical staff, at the conclusion of any case in which he has been associated with a member of the associate or courtesy medical staff, shall transmit to the medical records librarian a memorandum stating whether, from his observation of competence insofar as the particular case is concerned, the member of the associate or courtesy medical staff may be granted further privileges as specified in section 1 of this article. Such expression of opinion shall be kept as absolutely confidential by the medical records librarian and shall be accessible only to the credentials committee when making recommendations for promotion, appointment to service, or granting of increased privileges.

#### Section 5. Recommendations for Promotion or Appointment to Services

When making recommendations for promotion, appointment to services, or the granting of privileges, the credentials committee shall base its judgment on the consensus as determined under section 4 of this article, together with the record of performance as provided in section 3 of this article, and on the further qualifications of the member of the staff as shown in his filed credentials.

### *Article VII. Officers and Committees*

#### Section 1. Officers

The officers of the medical staff shall be the president, the vice president, and the secretary. These shall be elected at the annual meeting of the medical staff, and shall hold office until the next annual meeting or until a successor is elected.

The president, who shall also be the chief of the medical staff, shall call and preside at all meetings, shall be a member *ex officio* of all committees, and shall have general supervision over all of the professional work of the hospital.

The vice president in the absence of the president shall assume all his duties and have all his authority. He shall also be expected to perform such duties of supervision as may be assigned to him by the president.

The secretary shall keep accurate and complete minutes of all meetings, call meetings on order of the president, attend to all correspondence, and perform such other duties as ordinarily pertain to his office. If there are funds to be accounted for, he shall also act as treasurer.

#### Section 2. Committees

Committees of the medical staff shall be standing and special. All committees other than the executive shall be appointed by the president.

The executive committee shall consist of the president and secretary of the medical staff and of three other members of the active medical staff to be elected at the time of the annual meeting. The duties of the executive committee shall be to consider carefully and act on all matters which are not of a clinical nature and it is to be expected that all such business of the medical staff shall be transacted by the executive committee in order that the time of the regular meetings

of the medical staff may be devoted to matters pertaining to the professional care of patients. The executive committee shall present, at each meeting of the medical staff, a report of any action that it may have taken since the last meeting. The executive committee shall act as a liaison group between the medical staff and the administration of the hospital.

The medical records committee shall consist of three members of the medical staff and shall meet weekly for the purpose of reviewing the records of all patients discharged during the week. The committee shall report to the medical staff the names of any members who are persistently delinquent in the completion of their records. It shall also act as a program committee and shall be responsible for the preparation and presentation of all programs.

The credentials committee shall consist of not less than three nor more than seven members, the number and selection being determined in such a manner as to insure representation of the different services which are represented on the medical staff. Its duties shall be to investigate the credentials of all applicants for membership and to make recommendations in conformity with article III, section 5c, of these bylaws; to investigate any breach of ethics that may be reported; to review any records that may be referred by the medical director and to arrive at a decision regarding the performance of the medical staff member, or to refer the case to the full medical staff if this is considered desirable; to review all information available regarding the competence of medical staff members and as a result of such reviews to make recommendations for granting of privileges and the appointment of members to the various services and departments as provided in article VI of these bylaws.

The intern committee shall consist of three members of the medical staff. Its duties shall be to act as an advisory committee in the selection of interns, to outline courses of instruction for the resident medical staff and to see that they are carried out, and to assist the administration in matters of government and discipline of the resident medical staff.

Special committees shall be appointed from time to time as may be required to carry out properly the duties of the medical staff. Such committees shall confine their work to the purposes for which they were appointed and shall report to the full medical staff. They shall not have power of action unless such is specifically granted by the motion which created the committee.

### *Article VIII. Meetings*

#### **Section 1. The Annual Meeting**

The annual meeting of the medical staff shall be the last meeting before the end of the fiscal year of the hospital. At this meeting the retiring officers and committees shall make such reports as may be desirable, officers for the ensuing year shall be elected, and recommendations for appointment to the active medical staff shall be made.

#### **Section 2. Regular Meetings**

Regular meetings of the medical staff shall be held at least monthly at a time and place to be provided in the rules and regulations for the government of the medical staff.

#### **Section 3. Special Meetings**

Special meetings of the medical staff may be called at any time by the president and shall be called at the request of any five members of the active medical staff.

#### **Section 4. Attendance at Meetings**

(a) All members of the active medical staff shall be required to attend all meetings. Absence from three consecutive meetings or from one-third of the regular meetings for the year, without acceptable excuse, shall be considered as resignation from the active medical staff, and shall automatically place the absentee on the associate medical staff of the hospital.

(b) All members of the associate medical staff shall be expected to attend meetings with the same regularity as members of the active medical staff. Absence from three consecutive meetings or from one-third of the meetings of the year, without acceptable excuse, shall be considered as resignation from the associate medical staff and shall automatically place the absentee on the courtesy medical staff.

(c) Reinstatement of members of the active and associate medical staffs to positions rendered vacant because of absence from meetings may be made on application, the procedure being the same as in the case of original appointment.

(d) Members of the honorary, consulting, and courtesy divisions of the medical staff shall not be required to attend meetings, but it is expected that they will attend and participate in these meetings unless they are unavoidably prevented from doing so.

(e) A member of any division of the medical staff who has attended a case that is to be presented for discussion at any meeting shall be notified and shall be required to be present. Failure to attend on receipt of such notice shall involve the penalty, in the case of a member of the consulting or active staff, of reverting to the courtesy staff, and, in the case of a member of the courtesy staff, of forfeiting his staff membership.

(f) Should a member of the medical staff be absent from any meeting at which a case that he has attended is to be present, it shall nevertheless be discussed unless the member is unavoidably absent and has requested postponement of the discussion. In no case shall such postponement be granted for a period longer than that which will elapse until the next regular staff meeting.

### Section 5. Quorum

Fifty percent of the total membership of the active medical staff shall constitute a quorum.

### Section 6. Agenda

The agenda at any regular meeting shall be:

#### A. Business:

1. Call to order.
2. Reading of the minutes of the last regular and of all special meetings.
3. Unfinished business.
4. Communications.
5. Reports of standing and of special business committees.
6. New business.

#### B. Medical:

7. Review of patients in the hospital with special reference to diagnoses, treatment, and delayed recovery; selected cases discharged since the last conference with special consideration of selected deaths, unimproved cases, infections, complications, errors in diagnoses, and results of treatment; and analysis of clinical reports from the various departments.
8. Reports of standing and of special medical staff committees.
9. Discussion and recommendations for improvement of the professional work of the hospital.
10. Adjournment.

The agenda at special meetings shall be:

1. Reading of the notice calling the meeting.
2. Discussion of the business for which the meeting was called.
3. Adjournment.

### Article IX. Rules and Regulations

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these bylaws, except that they may be amended at any regular meeting without previous notice by a two-thirds vote of the total membership of the active medical staff. Such amendments shall become effective when approved by the governing board.

### Article X. Amendments

These bylaws may be amended after notice given at any regular meeting of the active medical staff. Such notice shall be laid on the table until the next regular meeting and a two-thirds majority of those present shall be required for adoption. Amendments so made shall be effective when approved by the governing board.



*Article XI. Adoption*

These bylaws shall be adopted at any regular meeting of the active medical staff and shall become effective when approved by the governing board of the hospital. They shall, when adopted and approved, be equally binding on the governing board and the medical staff.

Adopted by the medical staff of \_\_\_\_\_ Hospital

\_\_\_\_\_  
President of medical staff

\_\_\_\_\_  
Secretary of medical staff

Date \_\_\_\_\_

Approved by the governing board of \_\_\_\_\_

\_\_\_\_\_  
Hospital

\_\_\_\_\_  
Secretary of the governing board

Date \_\_\_\_\_

*Rules and Regulations*

1. The monthly meeting of the medical staff shall be held \_\_\_\_\_

2. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the director secured. In case of emergency the provisional diagnosis shall be stated as soon after admission as possible.

3. Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever.

4. All free patients shall be attended by members of the active medical staff, and shall be assigned to the service concerned in the treatment of the disease which necessitated admission or in rotation if there is no service division. No physician shall receive any compensation for attendance in the case of any patient who is admitted free by the hospital. Pay patients shall be attended by their own private physicians. In the case of a pay patient applying for admission who has no attending physician, he shall be assigned to the members of the active medical staff on duty in the service to which the illness of the patient indicates assignment.

5. Laboratories shall be provided in the hospital to insure as complete a service as possible. Examinations which cannot be made in the hospital shall be referred to an outside approved laboratory and in the case of pay patients will be charged to the patient at cost.

6. Standing orders shall be formulated by conference between the medical staff and the director. They may be changed only by the director after conference with the medical staff. These orders shall be followed insofar as proper treatment of the patient will allow, and when specific orders are not written by the attending physician they shall constitute the orders for treatment.

7. All orders for treatment shall be in writing. Verbal orders shall not be accepted or carried out. An order shall be considered to be in writing if dictated to a senior nurse or other authorized person and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his or her own name. At his next visit the attending physician shall sign such orders.

8. As far as possible the use of proprietary remedies shall be avoided. When such are ordered for private patients by the attending physician, they will be secured and a special charge made to the patient.

9. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultation, clinical laboratory, X-ray, and others; provisional diagnosis; medical or surgical treatment; pathological findings; progress notes; final diagnosis; condition on discharge; follow-up; and autopsy report when available. No medical record shall be filed until it is complete, except on order of the medical records committee.

10. A complete history and physical examination shall in all cases be written within 24 hours after admission of the patient.

11. When such history and physical examination are not recorded before the time stated for operation, the operation shall be canceled, unless the attending surgeon states in writing that such delay would be detrimental to the patient.

12. All records are the property of the hospital and shall not be taken away without permission. In case of readmission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient be free or pay, and whether he be attended by the same physician or by another.

13. Except in cases of emergency, patients for operation shall be admitted not later than four o'clock the day previous to operation.

14. All operations performed shall be fully described by the attending surgeon. All tissues removed at operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

15. In all cases where a patient is admitted in a condition of abortion, she or her representative shall sign a statement certifying that neither any employee of the hospital nor the attending physician was directly or indirectly responsible for its production.

16. Except in emergency, consultation with a member of the consulting or of the active medical staff shall be required in all major cases in which the patient is not a good risk and in all curettages or other operations which may interrupt a known, suspected, or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case. In all cases where a rule of the hospital requires consultation and in the case of free patients, the consultant shall give his services without charge.

17. Each member of the courtesy medical staff, not resident in the city, or immediate vicinity, shall name a member of the medical staff who is resident in the city, who may be called to attend his patients in emergency. In case of failure to name such associate, the director of the hospital shall have authority to call any member of the staff should he consider it necessary.

18. Patients shall be discharged only on written order of the attending physician. At the time of discharge the attending physician shall see that the record is complete, state his final diagnosis, and sign the record.

19. At the monthly meeting of the medical staff the medical records librarian shall submit a report of the professional work of the hospital for the previous month. This shall show patients discharged and the results, deaths (the cause being stated as given by the attending physician), autopsies, consultations, and infections of all kinds. The discussion at the meeting shall be based on this report and at no meeting shall abstract discussion of scientific medical subjects be permitted. After each meeting the secretary of the medical staff shall transmit to the director of the hospital such reports and recommendations as the medical staff may wish to make to him or through him to the governing board.

20. Every member of the medical staff shall be actively interested in securing autopsies whenever possible. No autopsy shall be performed without written consent of a responsible relative or friend. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty.

21. The hospital shall admit patients suffering from all types of disease except the following: (Specify diseases not treated). Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the medical staff.

Adopted at a regular meeting of the active medical staff.

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President of medical staff

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Secretary of medical staff

Date -----

Approved by the governing board.

-----  
Secretary of the governing board

Date -----

#### TYPE III HOSPITAL (OVER 150 BEDS)

The hospital is owned by a church, fraternal organization, the community, or a joint stock company. It is organized not for profit and admits free, part pay, and pay patients. Free patients are attended by the active medical staff:

pay patients are usually referred by their own physician and are attended by him. Some pay patients will apply for admission who have no attending physician and must be assigned by the hospital.

The hospital is one of over 150 beds. Its medical staff is comprised almost entirely of physicians who are definitely specialized and the hospital is strictly departmentalized.

Each hospital must use its initiative in formulating bylaws, rules, and regulations which are applicable to its own needs. Those portions of the following sample bylaws, rules, and regulations in the suggested form which do not pertain to a given hospital or which cannot become operable within the instruction should be modified. There are, however, a number of major principles which are fundamental and which should be embodied in all medical staff bylaws, rules, and regulations in order to comply with the minimum requirements of Hospital Standardization. These are outlined under "clause III of the Minimum Standard for Hospitals" (pp. 21 and 22).

Since the governing board is responsible for the conduct of the hospital, the bylaws, rules, and regulations should be officially adopted and attested by the signatures of its chairman and secretary in order to make the document effective. Finally, the signatures of all members of the medical staff should be affixed as evidence of good faith and agreement to abide thereby. In order to prevent the bylaws from becoming antiquated and disregarded, they should be revised every 3 to 5 years by a committee of the medical staff and the director of the hospital, approved by the governing board, and a copy placed in the minute book of the medical staff proceedings for ready reference.

### *Bylaws Preamble*

Recognizing that the best interests of the patient are protected by concerted effort, the physicians practicing in \_\_\_\_\_ Hospital hereby organize themselves in conformity with the bylaws, rules, and regulations herein-after stated.

For the purpose of these bylaws the word medical staff shall be interpreted to include all physicians who are privileged to attend patients in \_\_\_\_\_ Hospital.

Whenever the term "governing board" appears, it shall be interpreted to refer to the board of directors, the board of trustees, the board of managers, or other controlling group.

### *Article I. Name*

The name of this organization shall be the "Medical Staff of \_\_\_\_\_ Hospital."

### *Article II. Purpose*

The purpose of the organization shall be:

1. To insure that all patients admitted to the hospital or treated in the outpatient department receive the best possible care.

2. To provide a means whereby problems of a medico-administrative nature may be discussed by the medical staff with the governing board and the administration.

3. To initiate and maintain self-government.

4. To provide education and to maintain educational standards.

### *Article III. Membership*

#### *Section I. Qualifications*

The applicant for membership on the medical staff shall be a graduate of an approved medical school, legally licensed to practice in the state (or province) of \_\_\_\_\_, qualified for membership in the local medical society, and practicing in the community or within reasonable distance of the hospital.

#### *Section 2. Ethics and Ethical Relationships*

The code of ethics as adopted by the American Medical Association and the "Principles of Financial Relations in the Professional Care of the Patient" of the American College of Surgeons shall govern the professional conduct of the members of the medical staff. Specifically, all members of the medical staff shall pledge themselves that they will not receive from or pay to another physician,



either directly or indirectly, any part of a fee received for professional services. On the contrary it shall be agreed that all fees shall be collected and retained by the individual physician in accordance with the value of services rendered.

### Section 3. Application for Membership

Application for membership on the medical staff shall be presented in writing, on the prescribed form, which shall state the qualifications and references of the applicant, and shall also signify his agreement to abide by the bylaws, rules, and regulations of the medical staff.

### Section 4. Terms of Appointment

(a) Appointments to the medical staff shall be made by the governing board of the hospital and shall be for the period of 1 year or until the end of the fiscal year of the hospital. At the end of the fiscal year the governing board of the hospital may reappoint all members of the medical staff for a further period of 1 year, provided the medical staff has not recommended that any specific appointment shall not be renewed. In such case all other reappointments may be made.

(b) Should the governing board wish to take the initiative in refusing to make reappointment of any member, it shall so advise the medical staff, stating reasons and asking for recommendations as to further action.

(c) In no case shall the governing board take action on an application, refuse to renew an appointment, or cancel an appointment previously made without conference with the medical staff, but regardless of the recommendations of the medical staff, final responsibility for appointment or cancellation of an appointment must rest with the governing board.

(d) Appointment to the medical staff shall confer on the appointee only such privileges as may be hereinafter provided.

### Section 5. Procedure for Appointment

(a) The application for membership on the medical staff shall be presented to the director of the hospital and by him referred to the secretary of the medical staff.

(b) At the first regular meeting thereafter, the secretary shall present the application to the medical staff, at which time it shall be either recommended for rejection or referred to the credentials committee.

(c) The credentials committee shall investigate the character, qualifications, and standing of the applicant and shall submit a report of findings at the next regular meeting of the medical staff, or as soon thereafter as possible, recommending that the application be accepted, deferred, or rejected. In no case shall this report be delayed for more than 3 months.

(d) When determining qualifications, the credentials committee shall also assign privileges as provided in article VI, sections 1 and 2 of these bylaws.

(e) On receipt of the report of the credentials committee, the medical staff shall immediately recommend to the governing board that the application be accepted, deferred, or rejected.

(f) The recommendation of the medical staff shall be transmitted to the governing board through the director of the hospital.

(g) The governing board shall either accept the recommendation of the medical staff or shall refer it back for further consideration. In the latter case the governing board shall instruct its secretary to state to the medical staff the reasons for such action.

(h) When final action has been taken by the governing board, the director of the hospital shall be authorized to transmit this decision to the candidate for membership, and if he is accepted, to secure his signature to these bylaws, rules, and regulations. Such signature shall constitute his agreement to be governed by the said bylaws, rules, and regulations.

### Section 6. Emergency and Temporary Privileges

(a) In case of emergency the physician attending the patient shall be expected to do all in his power to save the life of the patient, including the calling of such consultation as may be quickly available. For the purpose of this section, an emergency is defined as a condition in which the life of the patient is in im

mediate danger and in which any delay in administering treatment would add to that danger.

(b) The director of the hospital shall have the authority to grant temporary privileges to a physician who is a member of the local medical society and desires to attend an occasional patient in the hospital but who is not a member of the medical staff. Such temporary privileges shall be granted after conference with the chief of staff or the medical director to determine an authoritative opinion as to the competence and ethical standing of the physician who desires such temporary privileges, and in the exercise of such privileges he shall be under direct supervision of the chief of staff. Temporary privileges may not be granted to attend more than four patients in any one year, after which the physician to whom temporary privileges have been granted shall be required to become a member of the medical staff before being allowed to attend additional patients.

#### *Article IV. Divisions of the Medical Staff*

##### **Section 1. The Medical Staff**

The medical staff shall be divided into honorary, consulting, active, associate, and courtesy groups.

##### **Section 2. The Honorary Medical Staff**

The honorary medical staff shall consist of physicians who are not active in the hospital and who are honored by emeritus positions. These may be physicians who have retired from active hospital service or physicians of outstanding reputation not necessarily resident in the community.

The honorary medical staff shall be appointed by the governing board on recommendation of the active medical staff and shall have no assigned duties or responsibilities. Their privileges shall be determined by the credentials committee as provided in Article VI of these bylaws.

##### **Section 3. The Consulting Medical Staff**

(a) The consulting medical staff shall consist of recognized specialists who are active in the hospital or who have signified willingness to accept such appointment. These may be fellows of the American College of Surgeons or the American College of Physicians, diplomates of one of the national boards of medical specialties, members of the national society representing the speciality, or others whom the credentials committee may consider to be worthy of being appointed as members of the consulting medical staff. Membership on the consulting medical staff shall not render the member ineligible for membership on the active medical staff.

(b) Appointment shall be made by the governing board on recommendation of the active medical staff. Credentials shall not be required for such appointments and the proposed member may be invited to accept appointment.

(c) The duties of the members of the consulting medical staff shall be to give their services without charge in the care of free patients on request of any member of the active medical staff, and also in any case in which consultation is required by the rules of the hospital.

(d) Insofar as their specialty is concerned, members of the consulting medical staff shall have unrestricted privileges, but in cases not falling within their specialty they shall have such privileges as may be determined by the credentials committee as provided in article VI of these bylaws.

##### **Section 4. The Active Medical Staff**

(a) The active medical staff shall consist of physicians who have been selected to attend free patients in the hospital and to whom all such patients shall be assigned. Members of the active medical staff shall not be required to be exclusive specialists, but it is to be expected that they will be well-skilled in the particular branch of medicine to which they are assigned, and that the major part of their private practice will fall within that specialty.

(b) Appointments shall be made annually by the governing board on recommendation of the active medical staff from the former members of the active medical staff, and insofar as it is possible, vacancies shall be filled by promo-

tion of members of the associate medical staff who have signified a desire to become more active in the work of the hospital.

(c) The duties of the active medical staff shall be to attend all free patients and, insofar as free work is concerned, they shall attend only such patients as are admitted to their services. All business of the medical staff shall be transacted by the active medical staff and only members of the active medical staff shall be eligible to vote and hold office.

(d) Insofar as free cases are concerned, members of the active medical staff shall treat patients in both the in- and out-patient departments as assigned to the service and in the treatment of these they shall have unrestricted privileges and shall treat the patient to a conclusion, whether such treatment is given in the in- or out-patient department or both. Insofar as private patients are concerned, they shall have unrestricted privileges in the treatment of patients falling within the specialty to which they are appointed, but in others they shall have only such privileges as may be determined by the credentials committee in conformity with article VI of these bylaws.

#### Section 5. The Associate Medical Staff

(a) The associate medical staff shall consist of junior and less experienced members or of physicians who have not been actively interested in the work of the hospital but have expressed a wish to become active as vacancies occur.

(b) They shall be appointed and assigned to services in the same manner as provided for the active medical staff and each shall be associated as junior with a member of the active medical staff.

(c) The duties of the members of the associate medical staff shall be to attend free patients in accordance with assignment by the senior with whom they are associated. They may be required also to act on all committees except the executive committee and the credentials committee.

(d) Insofar as free cases are concerned, the members of the associate medical staff shall be limited to the treatment of cases falling within the service to which they are appointed and in accordance with assignment by the member of the active medical staff with whom they are associated. Insofar as private patients are concerned, they shall have such privileges as provided by the credentials committee in article VI of these bylaws.

#### Section 6. The Courtesy Medical Staff

The courtesy medical staff shall consist of those members of the medical profession, eligible as herein provided for medical staff membership, who wish to attend private patients in the hospital, but who do not wish to become members of the active medical staff or who, by reason of residence, are not eligible for such appointment. They shall be appointed in the same manner as other members of the medical staff and they shall have such privileges as may be determined by the credentials committee in conformity with article VI of these bylaws, but they shall not be eligible to vote or hold office.

### Article V. Clinical Departments

#### Section I. Services

Divisions or services of the medical staff shall be as follows: Medicine to include cardiology, communicable diseases, dermatology and syphilology, diseases of the lungs, diseases of metabolism, endocrinology, gastrointestinal diseases, neuropsychiatry, pediatrics; surgery to include malignant tumor surgery, neurological surgery, obstetrics and gynecology, ophthalmology, otorhinolaryngology, oral surgery, orthopedics, plastic surgery, proctology, thoracic surgery, traumatic surgery, urology; and other services related to the specialties of radiology; pathology; anesthesia.

#### Section 2. Specialization

While the members of the active and associate services shall not be required to be exclusive specialists, it is to be expected that they will be well-skilled in the specialty to which they are assigned and that not less than 50 percent of their private work in the hospital shall be in that specialty. The chief of each service shall be a recognized specialist.



### Section 3. Assignment to Services

Assignment to the service shall be made at the first meeting of the active medical staff after its members have been appointed by the governing board and members so assigned shall remain on service for one year or until a successor has been appointed. Appointments shall be made after a careful analysis of the efficiency of the candidate as shown by a record of his work in the hospital.

### Section 4. Organization of Services

(a) At the annual meeting there shall be elected a chief of the medical staff who shall be a member of the active medical staff. He shall be responsible for the functioning of the clinical organization of the hospital and shall keep or cause to be kept a careful supervision over the clinical work in all divisions and services. He may, if desired, also be elected as president of the medical staff.

(b) Each service shall be organized as a division of the medical staff and shall have as its head a chief of service, who shall be responsible to the chief of the medical staff for the functioning of his service and shall have general supervision over the clinical work falling within his service whether it be free or private.

(c) Immediately after appointment, the members of the active medical staff in each service shall meet and each shall designate the member or members of the associate medical staff whom they wish to have as their assistants.

(d) The members of each service division shall meet during the first two weeks after they are appointed for the purposes of electing a chief of service and a secretary, and of perfecting such organization and arranging such a schedule of duties for their term of office as may seem advisable to promote the best interests of the patients.

(e) In the medical and surgical services there shall be elected also an assistant chief for each service who shall perform such duties as may be assigned by the chief of service. The members of the services shall be responsible to the chiefs of services and through them to the chief of the medical staff.

(f) Each service may meet separately, but such meetings shall not release the members from their obligation to attend the general meetings of the medical staff.

(g) Insofar as free cases are concerned, members of the active medical staff shall treat patients in both the in- and out-patient departments as assigned to the service and in the treatment of these, they shall have unrestricted privileges and shall treat the patient to a conclusion, whether such treatment is given in the in- or out-patient department or both. Insofar as private patients are concerned they shall have unrestricted privileges in the treatment of patients falling within the specialty to which they are appointed, but in others they shall have only such privileges as may be provided by the credentials committee in article VI.

## *Article VI. Determination of Qualifications and Privileges*

### Section 1. Classification of Privileges

Privileges extended to physicians who have been appointed to the medical staff shall be divided into major, intermediate, and minor, and shall be determined by the credentials committee. The following shall serve as a guide in differentiating the three types of privileges:

(a) Major privileges in any service will allow the physician to treat patients when, for any cause, such treatment involves a serious hazard to the life of the patient.

(b) Intermediate privileges in any service will allow the physician to treat patients when, for any cause, such treatment does not involve a serious hazard to the life of the patient but does involve a danger of disability.

(c) Minor privileges in any service will allow the physician to treat patients when, for any cause, the treatment does not involve either a serious hazard to the life of the patient or a danger of disability.

### Section 2. Newly Appointed Medical Staff Members

All members of the staff when newly appointed shall be granted only minor privileges until such time as the credentials committee may determine what

further privileges may be granted with safety to the patient, such extension of privileges being based, as far as possible, on records of performance as provided in sections 3 and 4 of this article.

### Section 3. Professional Service Accounting

A system of professional service accounting shall be maintained under which records of performance of each member of the staff shall be available.

(a) On or immediately after admission of the patient the attending physician shall classify the treatment proposed, in conformity with the pathology found, under one of the following prognostic categories:

<i>Elective</i>	<i>Emergency</i>	<i>Palliative</i>
1. Good	4. Good	7. Good
2. Fair	5. Fair	8. Fair
3. Bad	6. Bad	9. Bad

Should the attending physician consider the risk to be fair or bad in any of the categories or should he subsequently desire to change his prognosis, he shall be required to state his reasons. At the time of discharge, the immediate result shall be stated as recovered or died.

(b) The professional service accounting shall be administered by a professional service accountant, appointed by the administration with the advice of the medical staff, whose duty it shall be to check the prognosis and statement of results to determine whether they are correctly stated; to determine whether the result is such as may be reasonably expected from the prognosis and, if not, whether the result is justified or inevitable; and to determine any errors that may be apparent as evidenced by the medical record.

(c) In cases in which the professional service accountant does not feel competent to pass judgment or in which there may be reason for discussion the record shall be referred to the credentials committee who may exercise judgment or refer the case to the active medical staff for discussion and decision.

(d) The decision of the professional service accountant, of the credentials committee, or of the active medical staff, as the case may be, together with any comment that should be recorded, shall be attached as a memorandum to the medical record. This memorandum shall not be preserved as a part of the medical record.

(e) The medical records librarian shall keep a record of the performance of each physician, and she shall enter the decisions and remarks as above provided except that no record of errors shall be kept after the medical staff has taken appropriate action. This record shall be kept confidential and shall be accessible only to the credentials committee when determining the recommendations which it will make for promotion and appointment to the various services except that any member of the staff desiring information as to his own performance may have access to his own section of the record at any time. After all entries for the year have been made, the various columns shall be totaled.

### Section 4. Direct Observation

Every member of the consulting or active medical staff, at the conclusion of any case in which he has been associated with a member of the associate or courtesy medical staff, shall transmit to the medical records librarian a memorandum stating whether, from his observation of competence insofar as the particular case is concerned, the member of the associate or courtesy medical staff may be granted further privileges as specified in section 1 of this article. Such expression of opinion shall be kept as absolutely confidential by the medical records librarian and shall be accessible only to the credentials committee when making recommendations for promotion, appointment to service, or granting of increased privileges.

### Section 5. Recommendations for Promotion or Appointment to Services

When making recommendations for promotion, appointment to services, or the granting of privileges, the credentials committee shall base its judgment on the consensus as determined under section 4 of this article, together with the opinion of the chief of service concerned, on the record of performance as provided in section 3 of this article, and on the further qualifications of the member of the staff as shown in his filed credentials.

*Article VII. Officers and Committees*

## Section 1. Officers

The officers of the medical staff shall be the president, the vice president, and the secretary. These shall be elected at the annual meeting of the medical staff, and shall hold office until the next annual meeting or until a successor is elected.

The president shall call and preside at all meetings and he shall be a member ex officio of all committees. He may, if it is so desired, also be elected as chief of the medical staff.

The vice president in the absence of the president shall assume all his duties and have all his authority. He shall also be expected to perform such duties of supervision as may be assigned to him by the president.

The secretary shall keep accurate and complete minutes of all meetings, call meetings on order of the president, attend to all correspondence, and perform such other duties as ordinarily pertain to his office. If there are funds to be accounted for, he shall also act as treasurer.

## Section 2. Committees

Committees shall be standing and special. All committees other than the executive shall be appointed by the president.

The executive committee shall consist of the president and secretary of the medical staff and of three other members of the active medical staff to be elected at the time of the annual meeting. The duties of the executive committee shall be to consider carefully and act on all matters which are not of a clinical nature, and it is to be expected that all such business of the medical staff shall be transacted by the executive committee in order that the time of the regular meetings of the medical staff may be devoted to matters pertaining to the professional care of patients. The executive committee shall present, at each meeting of the medical staff, a report of any action that it may have taken since the last meeting. The executive committee shall act as a liaison group between the medical staff and the administration of the hospital.

The medical records committee shall consist of three members of the medical staff and shall meet weekly for the purpose of reviewing the medical records of all patients discharged during the week. The committee shall report to the medical staff the names of any members who are persistently delinquent in the completion of their records. This committee shall be held responsible for notifying the program committee of any cases that should be presented before the medical staff.

The program committee shall consist of three members of the medical staff and shall be responsible for the preparation and presentation of the programs of all meetings.

The credentials committee shall consist of seven members of the consulting or active staff, so selected as to insure representation of the major specialties. Its duties shall be to investigate the credentials of all applicants for membership and to make recommendations in conformity with article III, section 5c, of these bylaws, to investigate any breach of ethics that may be reported; to review any records that may be referred by the medical director and to arrive at a decision regarding the performance of the staff member, or to refer the case to the full active medical staff if this is considered desirable; to review all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges and the appointment of members to the various services and departments as provided in article VI of these bylaws.

The intern committee shall consist of three members of the medical staff. Its duties shall be to act as an advisory committee in the selection of interns, to outline courses of instruction for the resident medical staff and to see that they are carried out, and to assist the administration in matters of government and discipline of the resident medical staff.

Special committees shall be appointed from time to time as may be required to carry out properly the duties of the medical staff. Such committees shall confine their work to the purposes for which they were appointed and shall



report to the full medical staff. They shall not have power of action unless such is specifically granted by the motion which created the committee.

### *Article VIII. Meetings*

#### **Section 1. The Annual Meeting**

The annual meeting of the medical staff shall be the last meeting before the end of the fiscal year of the hospital. At this meeting the retiring officers and committees shall make such reports as may be desirable, officers for the ensuing year shall be elected, and recommendations for appointment to the active medical staff shall be made.

#### **Section 2. Regular Meetings**

Regular meetings of the medical staff shall be held at least monthly at a time and place to be provided in the rules and regulations for the government of the medical staff.

#### **Section 3. Special Meetings**

Special meetings of the medical staff may be called at any time by the president and shall be called at the request of the governing board, the executive committee, or any five members of the active medical staff. At any special meeting no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be posted on the bulletin board in the staff room at least 48 hours before the time set for the meeting.

#### **Section 4. Attendance at Meetings**

(a) All members of the active medical staff shall be required to attend all meetings. Absence from three consecutive meetings or from one-third of the regular meetings for the year, without acceptable excuse, shall be considered as resignation from the active medical staff, and shall automatically place the absentee on the associate or courtesy medical staff of the hospital.

(b) All members of the associate medical staff shall be expected to attend meetings with the same regularity as members of the active medical staff. Absence from three consecutive meetings or from one-third of the meetings for the year, without acceptable excuse, shall be considered as resignation from the associate medical staff and shall automatically place the absentee on the courtesy medical staff.

(c) Reinstatement of members of the active and associate medical staffs to positions rendered vacant because of absence from meetings may be made on application, the procedure being the same as in the case of original appointment.

(d) Members of the honorary, consulting, and courtesy divisions of the medical staff shall not be required to attend meetings, but it is expected that they will attend and participate in these meetings unless they are unavoidably prevented from doing so.

(e) A member of any division of the staff who has attended a case that is to be presented for discussion at any meeting shall be notified and shall be required to be present. Failure to attend on receipt of such notice shall involve the penalty, in the case of a member of the consulting or active medical staff, of reverting to the associate medical staff and, in the case of a member of the courtesy medical staff, of forfeiting his medical staff membership.

(f) Should a member of the staff be absent from any meeting at which a case that he has attended is to be discussed, it shall nevertheless be discussed unless the member is unavoidably absent and has requested that discussion be postponed. In no case shall postponement be granted for a period longer than that which will elapse until the next regular staff meeting.

#### **Section 5. Quorum**

Fifty percent of the total membership of the active medical staff shall constitute a quorum.

## Section 6. Agenda

The agenda at any regular meeting shall be :

## A. Business :

1. Call to order.
2. Reading of the minutes of the last regular and of all special meetings.
3. Unfinished business.
4. Communications.
5. Reports of standing and of special business committees.
6. New business.

## B. Medical :

7. Review of patients in the hospital with special reference to diagnosis, treatment, and delayed recovery; selected cases discharged since the last conference with special consideration of selected deaths, unimproved cases, infections, complications, errors in diagnosis, and results of treatment; and analysis of clinical reports from the various departments.
8. Reports of standing and special medical committees.
9. Discussion and recommendations for improvement of the professional work of the hospital.
10. Adjournment.

The agenda at special meetings shall be :

1. Reading of the notice calling the meeting.
2. Discussion of the business for which the meeting was called.
3. Adjournment.

*Article IX. Rules and Regulations*

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these bylaws, except that they may be amended at any regular meeting without previous notice by a two-thirds vote of the total membership of the active medical staff. Such amendments shall become effective when approved by the governing board.

*Article X. Amendments*

These bylaws may be amended after notice given at any regular meeting of the medical staff. Such notice shall be referred to a special committee which shall report at the next regular meeting and shall require a two-thirds majority of those present for adoption. Amendments so made shall be effective when approved by the governing board.

*Article XI. Adoption*

These by-laws together with the appended rules and regulations shall be adopted at any regular meeting of the active medical staff, shall replace any previous bylaws, rules, and regulations, and shall become effective when approved by the governing board of the hospital. They shall, when adopted and approved, be equally binding on the governing board and the medical staff.

Adopted by the active medical staff of \_\_\_\_\_ Hospital.

\_\_\_\_\_  
President of medical staff

\_\_\_\_\_  
Secretary of medical staff

Date \_\_\_\_\_

Approved by the governing board of \_\_\_\_\_ Hospital.

\_\_\_\_\_  
Secretary of the governing board

Date \_\_\_\_\_

*Rules and Regulations*

1. The monthly meeting of the medical staff shall be held \_\_\_\_\_.
2. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the director secured. In case of emergency the provisional diagnosis shall be stated as soon after admission as possible.

3. Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever.

4. All free patients shall be attended by members of the active medical staff, and shall be assigned to the service concerned in the treatment of the disease which necessitated admission. The members of the active medical staff must assign a reasonable number of cases to the juniors who are associated with them and the member of the associate medical staff to whom the case is assigned shall carry on the treatment under supervision of the senior. No physician shall receive compensation for attendance in the case of any patient who is admitted free by the hospital, but in the case of patients from whom the hospital is receiving partial compensation the attending physician may charge a fee proportionate to that received by the hospital. Pay patients shall be attended by their own private physicians. In the case of a pay patient applying for admission who has no attending physician, he shall be assigned to the members of the active medical staff on duty in the service to which the illness of the patient indicates assignment.

5. Laboratories shall be provided in the hospital so that all types of laboratory examinations may be done.

6. Standing orders shall be formulated by conference between the medical staff and the director. They may be changed only by the director after conference with the medical staff. These orders shall be followed insofar as proper treatment of the patient will allow, and when specific orders are not written by the attending physician they shall constitute the orders for treatment. Standing orders shall not, however, replace or cancel those written for the specific patient.

7. All orders for treatment shall be in writing. Verbal orders shall not be accepted or carried out. An order shall be considered to be in writing if dictated to a senior nurse or other authorized person and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his or her own name. At his next visit the attending physician shall sign such orders, and neglect to do so shall be considered as acknowledgment of their correctness.

8. As far as possible the use of proprietary remedies shall be avoided. When such are ordered for private patients by the attending physician, they will be secured and a special charge made to the patient.

9. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory, X-ray, and others; provisional diagnosis; medical or surgical treatment; pathological findings; progress notes; final diagnosis; condition on discharge; follow-up; and autopsy report when available. No medical record shall be filed until it is complete, except on order of the medical records committee.

10. A complete history and physical examination shall in all cases be written within 24 hours after admission of the patient.

11. When such history and physical examination are not recorded before the time stated for operation, the operation shall be canceled, unless the attending surgeon states in writing that such delay would be detrimental to the patient.

12. All records are the property of the hospital and shall not be taken away without permission. In case of readmission of a patient all previous records shall be available for the use of the attending physician. This shall apply whether the patient be free or pay, and whether he be attended by the same physician or by another.

13. Except in cases of emergency, patients for operation shall be admitted not later than 4 o'clock the day previous to operation.

14. All operations performed shall be fully described by the attending surgeon. All tissues removed at operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

15. In all cases where a patient is admitted in a condition of abortion, she or her representative shall sign a statement certifying that neither any employee of the hospital nor the attending physician was directly or indirectly responsible for its production.

16. Except in emergency, consultation with a member of the consulting or of the active medical staff shall be required in all major cases in which the



patient is not a good risk and in all curettages or other operations which may interrupt a known, suspected, or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case. In all cases where a rule of the hospital requires consultation and in the case of free patients, the consultant shall give his services without charge.

17. Each member of the courtesy medical staff, not resident in the city, or immediate vicinity, shall name a member of the medical staff who is resident in the city, who may be called to attend his patients in emergency. In case of failure to name such associate, the director of the hospital shall have authority to call any member of the staff should he consider it necessary.

18. Patients shall be discharged only on written order of the attending physician. At the time of discharge the attending physician shall see that the record is complete, state his final diagnosis, and sign the record.

19. At the monthly meeting of the medical staff the medical records librarian shall submit a report of the professional work of the hospital for the previous month. This shall show patients discharged and the results, deaths (the cause being stated as given by the attending physician), autopsies, consultations, and infections of all kinds. The discussion at the meeting shall be based on this report and at no meeting shall abstract discussion of scientific medical subjects be permitted. After each meeting the secretary of the medical staff shall transmit to the director of the hospital such reports and recommendations as the medical staff may wish to make to him or through him to the governing board.

20. Every member of the medical staff shall be actively interested in securing autopsies whenever possible. No autopsy shall be performed without written consent of a responsible relative or friend. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty.

21. The hospital shall admit patients suffering from all types of disease except the following: (Specify diseases not treated). Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the medical staff.

22. Surgeons must be in the operating room and ready to commence operation at the time scheduled, and in no case will the operating room be held longer than 15 minutes after the time scheduled.

Adopted at a regular meeting of the active medical staff

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President of medical staff  
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Secretary of medical staff  
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Date-----

Approved by the governing board:

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Secretary of the governing board  
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Date-----

#### TYPE IV HOSPITAL (A HOSPITAL OF ANY SIZE, BUT USUALLY OF LESS THAN 50 BEDS)

The hospital is privately owned, either by a partnership which may be lay or medical, or by an industrial corporation. It is organized for profit and admits only pay patients.

The hospital may be of any size but is usually less than 50 beds. The medical staff is comprised of those physicians who own the hospital, or if it is owned by a lay corporation, the physicians are employed or controlled by the corporation.

Each hospital must use its initiative in formulating bylaws, rules, and regulations which are applicable to its own needs. Those portions of the following sample bylaws, rules, and regulations in the suggested form which do not pertain to a given hospital or which cannot become operable within the institution should be modified. There are, however, a number of major principles which are fundamental and which should be embodied in all medical staff bylaws, rules, and regulations in order to comply with the minimum requirements of hospital standardization. These are outlined under "clause III of the Minimum Standard for Hospitals" (pp. 21 and 22).

It is desirable to control the work of the medical staff, limiting each member to that which his training and experience have made him capable of carrying on successfully. Provision for adequate control may be made by selecting those parts of the bylaws for a hospital of type II which are applicable, and adapting them to the needs and possibilities of this particular type of hospital.

Since the governing board is responsible for the conduct of the hospital, the bylaws, rules, and regulations should be officially adopted and attested by the sig-

natures of its chairman and secretary in order to make the document effective. Finally, the signatures of all members of the medical staff should be affixed as evidence of good faith and agreement to abide thereby. In order to prevent the bylaws from becoming antiquated and disregarded, they should be revised every 3 to 5 years by a committee of the medical staff and the director of the hospital, approved by the governing board, and a copy placed in the minute book of the medical staff proceedings for ready reference.

### *Bylaws, Preamble*

Recognizing that the best interests of the patient are protected by concerted effort, the physicians practicing in \_\_\_\_\_ Hospital hereby organize themselves in conformity with the bylaws, rules, and regulations hereinafter stated. For the purpose of these bylaws the words "medical staff" shall be interpreted to include all physicians who are privileged to attend patients in \_\_\_\_\_ Hospital.

### *Article I. Name*

The name of this organization shall be the "Medical Staff of the \_\_\_\_\_ Hospital."

### *Article II. Membership*

#### *Section 1. Qualification*

Membership shall be limited to: (State name of partnership or otherwise define limitations of medical staff), all of whom are ethical physicians, graduates of approved medical schools, eligible for membership in the local medical society, and licensed to practice in the State (or Province) of \_\_\_\_\_

#### *Section 2. Assistant and Resident Physicians*

Assistant and resident physicians may be employed as the demands of practice may warrant. These shall be paid definite salaries and shall work under the direction of one or more of the group as may be determined. These assistant and resident physicians shall not be considered as members of the medical staff, and may or may not be licensed practitioners in the State (or Province) of \_\_\_\_\_ but shall conform to the same code of ethics as is required for members of the medical staff.

#### *Section 3. Ethics and Ethical Relationships*

The code of ethics as adopted by the American Medical Association and the Principles of Financial Relations in the Professional Care of the Patient of the American College of Surgeons shall govern the conduct of the staff and its individual members.

(If a partnership, insert these paragraphs:)

Inasmuch as the group is organized as a legal partnership, it is recognized that all fees for professional services shall accrue to the partnership. Each member shall draw his compensation in accordance with the terms of the partnership and each employed assistant or resident physician in accordance with the terms of his employment. Receipt of compensation in such a manner is recognized as an ethical business arrangement.

The members of the group as individuals and as a whole and on behalf of all assistant and resident physicians shall pledge themselves that in no case in which a patient is referred by an outside physician will they receive from or pay to the referring physician, directly or indirectly, any part of the fee for service to the patient. On the contrary it is agreed that all fees from patients shall be collected from the patient by the referring physician and the group, each separately in accordance with the value of services rendered, and that such fees will be retained as collected.

### *Article III. Staff Divisions and Services*

There shall be no divisions of the medical staff, but all shall be of the same standing and of equal authority in the professional conduct of the hospital. The following services shall be maintained:

Medicine, under a qualified internist.

Surgery, under a qualified surgeon.

(Define other service according to the qualifications of the physicians in the group.)

*Article IV. Officers and Committees***Section 1. Officers**

Officers of the medical staff shall consist of a chief of staff and a secretary. Both shall be elected at the annual meeting and shall hold office until the end of the fiscal year following the election or until a successor has been elected.

The chief of the medical staff shall also act as president of the medical staff, and in his absence shall name a substitute who shall perform his duties. He shall call and preside at all meetings, and shall have general supervision over all work in the hospital.

The secretary shall keep complete minutes of all meetings, and shall conduct the correspondence of the staff. He shall also be responsible for seeing that cases are selected for presentation at the meetings of the medical staff.

**Section 2. Committees**

There shall be no standing committees, but the medical staff as a whole shall act in the place of the usual standing committees. Special committees shall be appointed by the chief of the medical staff from time to time as occasion may arise.

*Article V. Meetings***Section 1. The Annual Meeting**

The annual meeting shall take place during the second week preceding the end of the fiscal year of the hospital and at this meeting the officers for the following year shall be elected.

**Section 2. Regular Meetings**

Regular meetings shall be held weekly. (Designate a day and hour.) At the second meeting of the month the medical records librarian shall present an analysis of the work of the hospital for the previous month, and the meeting shall be devoted to a study of this analysis and a general review of the medical records.

All other meetings shall be clinical in character and it is expected that insofar as the occurrence of cases of interest will allow, the members of the medical staff will rotate regularly in presenting cases for discussion. Members of the medical staff shall be expected to be present at all meetings. Fifty percent of the membership shall constitute a quorum.

**Section 3. Agenda**

Agenda shall be as follows:

**A. Business:**

1. Call to order.
2. Reading of the minutes of the last regular and of all special meetings.
3. Unfinished business.
4. Communications.
5. Reports of standing and of special business committees.
6. New business.

**B. Medical:**

7. Review of patients in the hospital with special reference to diagnoses, treatment, and delayed recovery; selected cases discharged since the last conference with special consideration of selected deaths, unimproved cases, infections, complications, errors in diagnoses, and results of treatment; and analysis of clinical reports from the various departments.
8. Reports of committees.
9. Discussion and recommendations for improvement of the professional work of the hospital.
10. Adjournment.

*Article VI. Rules and Regulations*

The staff shall adopt such rules and regulations as may be necessary for the proper conduct of the work of the hospital. Such rules and regulations shall



be a part of these bylaws except that they may be amended at any regular meeting without previous notice by a two-thirds vote of the members of the medical staff.

### *Article VII. Amendments*

These bylaws may be amended upon notice by any member of the medical staff at any regular meeting. Such notice shall be laid on the table for 1 month, after which time it may be adopted by a two-thirds majority of those members present at any regular meeting. Amendments shall be effective when adopted by the medical staff.

### *Rules and Regulations*

1. The hospital shall receive and treat patients suffering from the following types of disease: (State diseases in accordance with the qualifications of the constituent members of the group).

2. Patients shall be attended by members of the medical staff in accordance with the selection of the patient, but in every case it shall be the endeavor to have the patient placed in the service of the member who is best qualified to render service, and in all instances members of the medical staff shall collaborate as required in the best interests of the patient.

3. Laboratories shall be maintained in the hospital under a competent director to conduct the following laboratory examinations: (Name them). Arrangements shall be made to have any other laboratory examinations required by the attending physician done in an approved, ethical laboratory.

4. Routine orders shall be formulated insofar as possible and shall be incorporated in writing in "Standing Orders." Such routine orders may be changed only on order of the director of the hospital after approval at a regular meeting of the medical staff.

5. All orders for treatment shall be in writing. Verbal orders shall not be accepted or carried out. An order shall be considered to be in writing if dictated to a senior nurse or other authorized person and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his or her own name. At his next visit the physician shall sign such orders.

6. The attending physician shall be held responsible for seeing that a complete medical record is written for each patient. This record shall include identification data; complaint; personal history; family history; history of the present illness; physical examination; special reports such as consultations, clinical laboratory reports, X-ray reports, and others; provisional diagnosis; medical or surgical treatment; pathological findings; progress notes; final diagnosis; condition on discharge; follow-up; and autopsy report when available. No medical record shall be filed until it is complete.

7. A complete history and physical examination shall be written not later than 24 hours after admission and, except in emergency, shall be required before the patient goes to operation. When such history and physical examinations are not recorded before the time stated for operation, the operation shall be canceled unless the attending surgeon states in writing that such delay would be detrimental to the patient.

8. All records are the property of the hospital and shall not be taken away without permission. Should the patient be readmitted, all previous records shall be available for the use of the physician attending on the readmission.

9. Patients for operation shall be admitted not later than 4 o'clock of the day previous to operation. Exception may be made when the patient has been examined in the offices of the physician or group using the facilities of the hospital and a complete report of such examination is sent to the hospital at the time of admission, but in no case shall a patient be admitted less than 2 hours before the time set for operation.

10. All operations performed shall be fully described by the attending surgeon, and all tissues removed at operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

11. When a patient is admitted in a condition of abortion, she or her representative shall sign a statement certifying that neither any employee of the hospital nor the attending physician was directly or indirectly responsible for its production.

12. Except in emergency, consultation with a second member of the medical staff shall be required in all major cases in which the patient is not a good

risk, and in all curettages or other operations which may interrupt a known, suspected, or possible pregnancy. The consultant shall make and sign a record of his findings and recommendations in every such case.

Adopted at a regular meeting of the medical staff held

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Chief of medical staff

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Secretary of medical staff

#### ADDENDUM II—USE OF PROFESSIONAL SERVICE ACCOUNTING TO CONTROL EFFICIENCY<sup>1</sup>

The governing body of the hospital is responsible for its operation in every department, but because it is manifest that the members cannot personally attend to all of the details, an administrator is appointed who is the direct representative of the governing body.

Directly or through the administrator the governing body provides a physical plant with its equipment, and selects and organizes the necessary personnel. Usually the administrator needs no assistance in this phase of his work.

Collateral to the internal organization is the organized medical staff for whose efficiency the governing body is also responsible. In its selection and organization medical judgment is required, and since neither the governing body nor the administrator is qualified to exercise such judgment completely, they must have advice which carries the weight of medical authority.

The best means by which this consultation with medical authority can be secured is through the joint advisory committee which, insofar as it is required to advise on the competence of the medical staff, bases its opinions on information secured by the medical records committee, the professional service accountant, or the qualifications committee, sometimes called the auditing committee.

In the original selection of the medical staff the governing body is handicapped by lack of information about the applicant. All that is available is found in the credentials submitted and in the knowledge that the applicant has been accepted as a reputable physician by the local medical society. Data concerning his actual skill are only inferential.

This handicap can be overcome if proper records of the work of each member of the medical staffs are systematically kept. A constantly increasing amount of specific information accumulates which subsequently enables the governing body to grant privileges and make promotions, and appointments to the various divisions and services depend almost entirely on records of efficiency. Such a system involves systematized accounting of the professional work of the hospital, and, to be successful, it requires certain basic data and an organization qualified to make proper use of the data.

1. The medical record of the patient is the record of original entry which contains the basic data necessary for professional service accounting. It must, therefore, contain a true and accurate story of the illness as it has affected the patient. It must show the means used to establish a diagnosis, the treatment administered, the progress of the case, and the result insofar as this can be ascertained. If end results cannot be secured, those that are apparent at the time of discharge must be used. It is the duty of the medical records committee to see that the attending physician places such a record on file.

2. At the time of admission or as soon thereafter as possible, the attending physician is required to state in the record his estimate of the risk in one of nine prognostic categories (Form I). If the risk is not good in any category, the attending physician should be required to state his reason for considering it fair or bad.

#### FORM I. ESTIMATE OF THE RISK

<i>Elective</i>	<i>Emergency</i>	<i>Palliative</i>
1. Good	4. Good	7. Good
2. Fair	5. Fair	8. Fair
3. Bad	6. Bad	9. Bad
Statement of result		
Recovered    Died		

3. At the time of discharge it is stated that the patient recovered or died (Form I). If end results can be secured, they may be given consideration at a later date and may modify the original estimate of efficiency.

<sup>1</sup> Submitted through the courtesy of Thomas R. Ponton, M. D., Chicago.

(b) If the result is such as can be reasonably expected from the prognosis.

### Review of Medical Record

Doctor \_\_\_\_\_ Hosp. No. \_\_\_\_\_

Date \_\_\_\_\_ Professional service accountant \_\_\_\_\_

Comment

Date \_\_\_\_\_ For Auditing Committee

(d) If any errors have been committed in the management of the case.

5. Records approved by the professional accountant are transmitted to the medical records librarian for indexing (Form III); those that show anything of a debatable nature are referred to the qualifications committee; any that have an educational value are referred to the program committee.

Service Code						PHYSICIANS' INDEX															
A Medicine	F Dermatology	K Urology				Doctor <u>Nemo</u>															
B Surgery	G Communicable	L Orthopedics				Division <u>Active</u> Service <u>Surgery</u>															
C Gynecology	H Pediatrics	M Neoplasms																			
D Obstetrics	I Miscellaneous	N Traumatic																			
E Eye, Ear, Nose and Throat																					
Hospital Number	Major	Intermediate	Minor	Service											Incomplete record	Results			Notes		
					1	2	3	4	5	6	7	8	9	Favorable		Inevitable	Justifiable				
					R	D	I	D	R	O	R	D	R	D		R	I	R		D	
83	I		B	I												I					
346	I		B	I													I		Goltre, no B.M. recorded		
370	I		N									I					I		Fracture femur, age 76		
546	I		N									I					I		Traumatic shock		
489	I		B					I									I		Secondary hemorrhage		
288	I		B			I											I		General peritonitis, cause unknown		
178	I		B	I													I		Ac appendicitis, in hosp 24 hours before operation, no blood count		
519	I		B									I					I		Ruptured peptic ulcer, operation refused at former admission		
485	I		B			I											I		Cholecystitis, posterior coronary		
772	I		C	I													I				
921	I		M														I		Carcinoma pylorus, obstruction		
																			(Others not shown)		
Totals	87	96	89	241		4	5	2	9	3		7				10	4	12	258	2	10



6. The qualifications committee is composed of representatives of the various specialities found in the hospital. It should be nominated by the medical staff and appointed by the governing body. It is the duty of the qualifications committee to review the information contained in all medical records referred by the professional accountant and to pass judgment as outlined above.

For each record so referred the qualifications committee should make a note expressing its opinion (Form II). This opinion is based solely on the data contained in the medical record, but the attending physician may have further information which would modify the judgment of the committee; hence this should be subject to review at the request of the attending physician.

Any case which has an educational value or on which the qualifications committee does not wish to pass final judgment should be referred to the full staff.

When errors are found, the medical staff and the governing body should take any action that may be indicated, in order that repetition may be prevented. It is inadvisable, however, to make any permanent record concerning such errors. After appropriate action has been taken, any memoranda regarding the error should be destroyed.

7. After the medical record has been reviewed by the professional accountant, the qualifications committee, or the full staff, it is the duty of the medical records librarian to make the proper entries in the physicians' index (Form III) which shows a record of the work of each member of the medical staff. Any comment that has been made by the qualifications committee or the full staff should be transferred to the physicians' index after which the memorandum may be destroyed.

8. The physicians' index (Form III) is kept as a confidential record and should be made available by the medical records librarian only as follows:

(a) Any physician may have access to his own record at any time but not to that of any other physician.

(b) The qualifications committee should have access to the entire index when making recommendations for granting privileges, for promotion, or for appointment to divisions or services.

9. At the end of the year, when all entries have been completed, the medical records librarian, with the assistance of the professional accountant, should total the pages showing the work of the individual members of the medical staff. She also makes a service analysis (Form V) which shows the number of major and minor cases which each member of the medical staff has treated in the various specialties, thereby indicating the service to which each should be assigned. Both of these records are then used by the qualifications committee as the basis for its recommendations for granting privileges, for promotion, or for appointment to the various divisions or services.

10. The committee should recommend a greater number than are required to fill positions available.

11. Up to this point the work of accounting should be in code (Form IV) each physician being assigned a code number, the key to which is kept by the medical records librarian. When the specific recommendations have been decided on, the code is translated and the names of the various physicians substituted for the code number.

#### FORM IV. RECOMMENDATIONS FOR STAFF APPOINTMENT

##### Active:

Surgical service—1, 6, 18, 31, 37, 39, 44, 51, 66.

Medical service—5, 8, 20, 34, 38, 41, 45, 68.

(Similar for other services.)

##### Associate:

Surgical service—4, 9, 12, 19, 24, 29, 33, 46.

Medical service—10, 16, 17, 23, 27, 30, 36, 43.

(Similar for other services.)

Courtesy staff—2, 13, 15, 40, 52, 56, 59, 60, 63, 64, 67.

Should be required to become member of courtesy staff or denied hospital privileges—3, 47, 48, 50.

12. The recommendations of the qualifications committee are transmitted to the joint advisory committee or to the full staff, as may be decided, and from

SERVICE ANALYSIS																											
Doctor	Medicine		Surgery		Gyn.		Obs		E.E.N.T.		Derm.		Comm.		Ped.		Urology		Ortho.		Tumor		Trauma		Misc		
	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	Major	Minor	
1	1	3	15	1	2		9		1	2			8			1	1	1	1	1	1	4		1			
2	2	3	5	1	3		8	1	3				1						2		1	2					
14	7	12	20		3	1	12	5	1	16			1		11	1	2			5		1	1				
21	5	5	11	1	2		15		1						15					1	1	2	2				
22	8	7	8		2	42	3	4							37					2	1	2		1			
33	2	2	11		2	27	2	5							26								2				
50	4	5	15	3		1	18	3	5				1		18			2			2	4	7				
63	5	5	14	4		1	5	2	2				1		5	1							2				
64	1	10	1	1			15	1	1						13	1						1	2				
66	4	10	40	4	3	1	27	2	1	38			1	1	1	27		4		1			5				
73	5	7	32	1	1	5	14	4	7								3		1		2	1	4				
75	2	4	11	5		3	20	1	8						20	1				1	1		1				
79	9	11	20	4	3	5	36	1	1	18	1	1	1	2	33				1	4	2	2	5				
109	13	18	36	7	2	1	19		8						18	2			1	5	2	1	5				
111	6	1	1	1	2	4	6						1		6	1	1			2	1		3				
(Others not shown)																											
Totals	118	199	424	83	44	43	507	47	4	240	1	5	5	13	148	15	22	5	5	35	29	107	138	1	4		

among those recommended the number required to fill the available positions are selected, giving consideration to the spirit of cooperation, ability to devote sufficient time to the work, and other personal considerations which make for a harmonious and efficient staff.

13. The nominations which are thus made are transmitted to the governing body for final appointment.

14. The summaries of the work of individuals are combined to give a summary analysis of the whole hospital (Form VI). This may lead to discovery of:

- Deficiency or completeness of equipment in the various departments.
- Efficiency or inefficiency of the personnel and its organization.
- Procedures that are effective and those that are ineffective.
- Points of weakness and strength in the individuals of the medical staff, in the organization, or in its functioning.

From the exact knowledge secured by means of these records, desirable features in the hospital and its internal organization may be perpetuated while those that are undesirable will be eliminated; but most important is the fact that the granting of privileges, promotions, and appointments to the various divisions and services are made from exact knowledge of the efficiency of the members of the medical staff in their use of the facilities provided for the care of the patients.

#### ADDENDUM IV. MEDICAL STAFF MINUTE BOOK

The medical staff has many medico-administrative and clinical duties to perform requiring the holding of certain meetings from time to time, the proceedings of which should be properly recorded in brief and comprehensive minutes. Too frequently the records of staff proceedings, medico-administrative and clinical, are badly neglected and thus are of little or no value. All hospitals should provide a minute book in which may be assembled in a systematic manner the minutes of the staff meetings as well as the reports of committees.

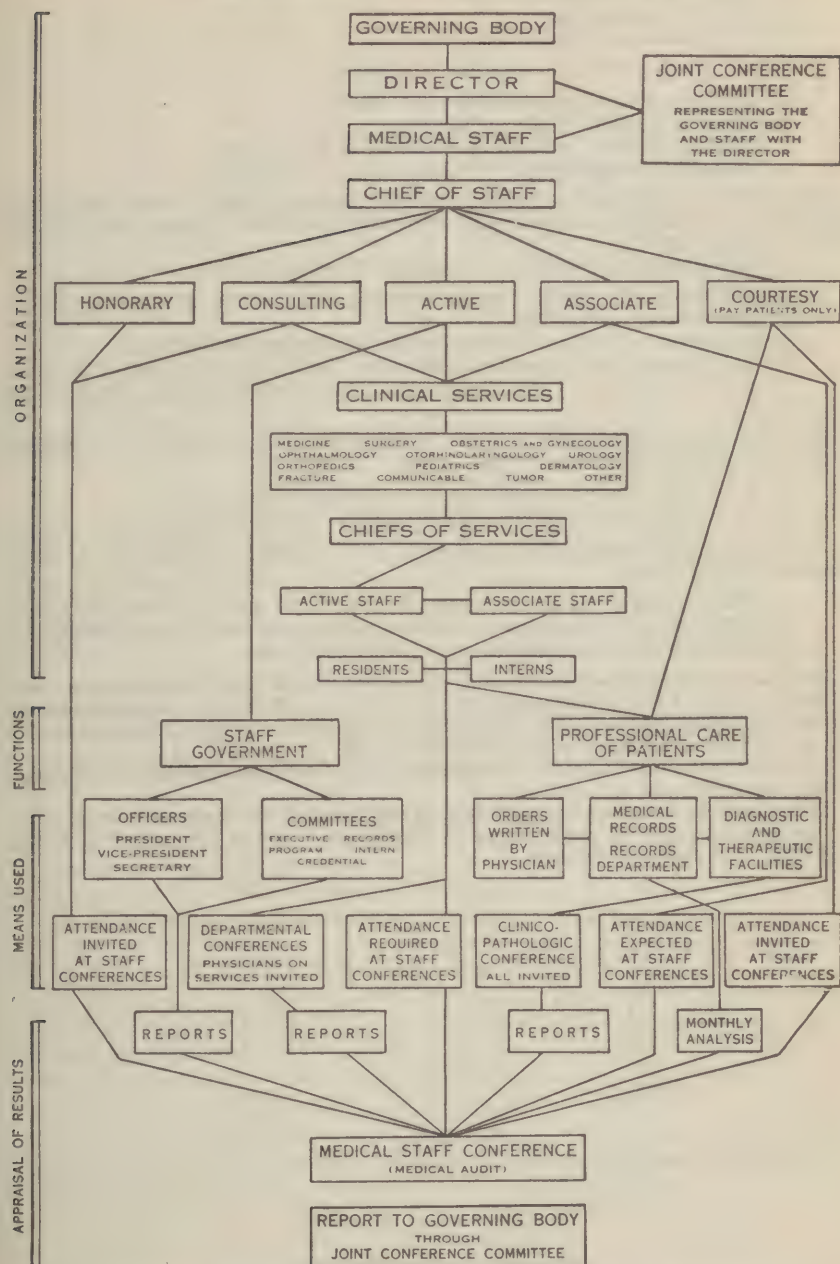
A loose-leaf book is most suitable for this purpose inasmuch as it allows for expansion as well as ready removal of pages for typing.

Doctor	Present Service	Number of records reviewed	Major			Intermediate			Minor			1		2		3		4		5		6		7		8		9		Incomplete records	Errors				Results			Notes																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	



# ADDENDUM III MEDICAL STAFF

OVER 150 BEDS -- PAY AND FREE PATIENTS -- FULL DEPARTMENTALIZATION



Reprinted from "Hospital Organization and Management" by Dr. M. T. MacEachern  
©Physicians' Record Co., 1935

The first section of the minute book provides pages for :

1. Index.
2. Bylaws, rules, and regulations.
3. Agenda for meetings.
4. Attendance at staff conferences.

The second section of the minute book includes :

1. Minutes of meetings, business and clinical.
2. Reports of group studies of diseases.
3. Monthly analysis reports of the work of the hospital.
4. Reports of committees.

The secretary of the medical staff must see that the minutes, reports of attendance, and other matters are promptly, accurately, and neatly typed, and inserted in the minute book.

In describing each case, the following data at least should be recorded :

1. The patient's number which identifies the record so that it can be referred to when necessary.
2. The nature of the case with outstanding or unusual features.
3. The name of the physician presenting the facts pertaining to the case.
4. The conclusions or the recommendations made from the study of the case.

When a stenographer takes a verbatim report of the minutes of the meeting it may be disposed of in either of two ways :

1. A complete copy incorporated in the minute book.
2. An abstract made of the various cases or items discussed.

Communications submitted at a meeting of the medical staff can be properly disposed of as follows :

1. Transcribed in the minutes with original letter and reply filed elsewhere.
2. Referred to in the minutes as having been read and filed elsewhere.
3. Perforated and incorporated in the minute book.

Some hospitals keep a supplementally loose leaf minute book for correspondence.

The minutes of the transactions of the medical staff, which should reflect the manner in which the staff is functioning, constitute valuable information for the governing board and the administrative staff.

The minutes when complete and approved by the medical staff should be signed by the secretary and the chairman.

The minute book must always be kept in the hospital for ready reference.

The minutes can be removed from the loose-leaf folder at the end of each year and bound for future reference.

# ADDENDUM V APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

Hospital _____	City and State _____
Name in full _____	Date _____
Office address _____	Telephone _____
Residence address _____	Telephone _____
Place and date of birth _____	Citizenship _____
Premedical education: College or university _____	
Date of graduation _____	Degree _____
Medical education: Medical school _____	
Date of graduation _____	Degree _____
Internship: Hospital _____	Date _____
_____	_____
_____	_____
Licensure: State or Province _____	Date _____
_____	_____
Graduate training following internship:	
Institution	Date
Residencies _____	_____
or _____	_____
fellowships _____	_____
_____	_____
Assistantships _____	_____
_____	_____
Teaching appointments _____	_____
_____	_____
Postgraduate education: _____	_____
_____	_____
Membership on other hospital staffs (past and present):	
_____	_____
_____	_____
Membership in medical societies: _____	
_____	_____
_____	_____
Fellowship in American College of Surgeons _____	Date _____
Fellowship in American College of Physicians _____	Date _____
Specialty _____	Certification by specialty board _____
_____	(Name of board)
References: _____	_____
_____	_____

(Give on a separate sheet a list of scientific papers or essays, and of national scientific meetings attended during the previous three years.)



## APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF—CONTINUED

The undersigned applies for membership on the medical staff of \_\_\_\_\_  
and for privileges of practice as indicated below: (Name of hospital)

General practice \_\_\_\_\_  
(Includes general medicine, diagnosis, non-operative obstetrics, minor surgery, first aid in emergencies)

Major or minor work desired:

General medicine \_\_\_\_\_

Medical specialties \_\_\_\_\_  
(Indicate medical specialties)

General surgery \_\_\_\_\_

Surgical specialties \_\_\_\_\_  
(Indicate surgical specialties)

Other Services \_\_\_\_\_  
(As anesthesia, pathology, radiology)

In making application for appointment to the medical staff of the \_\_\_\_\_  
HOSPITAL I agree to abide by the by-laws of the medical staff and by such rules and regulations as  
may be from time to time enacted. Moreover, I hereby declare that I shall not engage in the practice  
of the division of fees under any guise whatsoever. In complying with this principle, I understand  
that I am not to collect fees for others referring patients to me, nor permit others to collect fees  
for me, nor to make joint fees with physicians or surgeons referring patients to me for operation or  
consultation, nor permit any agent or associate of mine to do so.

Further, I agree to comply with the principle that all physicians and surgeons participating in the  
care of a patient shall render separate statements and issue separate receipts.

\_\_\_\_\_  
(Signature of applicant) M.D.

Appointment recommended \_\_\_\_\_ Appointment not recommended \_\_\_\_\_ Appointment deferred \_\_\_\_\_

Privileges limited to \_\_\_\_\_

Date \_\_\_\_\_

Secretary of Medical Staff

Appointed by Governing Board

Date \_\_\_\_\_

Secretary of Governing Board

Remarks: \_\_\_\_\_

## ADDENDUM VI

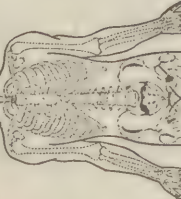

[illegible]





## ADDENDUM VII

[illegible]

Family History	Anterior	Posterior
Past History		
Present Injury		
(Details of Treatment, Operation, etc.)		

Form 19 ACH (REVISED MAR. 1927)

## ADDENDUM VIII

## SAMPLE\* SYNOPTIC CANCER RECORD FORMS

## MALIGNANT TUMOR OF RECTUM

Hospital or Clinic: \_\_\_\_\_

Classification: (see reverse) \_\_\_\_\_ Service \_\_\_\_\_ Hosp. or Clinic No. \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Age \_\_\_\_\_ M. or F. S. or M.

Family Physician \_\_\_\_\_ Address \_\_\_\_\_ Date of Entrance \_\_\_\_\_

Family History of Cancer: \_\_\_\_\_

PAST HISTORY: Change of Bowel Habit \_\_\_\_\_ Loose \_\_\_\_\_ Constipated \_\_\_\_\_ Hemorrhoids \_\_\_\_\_

## PRESENT HISTORY

SYMPTOMS OF ONSET: Dates \_\_\_\_\_

Nature \_\_\_\_\_

Date 1st Medical Consultation \_\_\_\_\_

Advice Given \_\_\_\_\_

Treatment Before Entrance \_\_\_\_\_

## SYMPTOMS AT ENTRANCE

Chief Complaint \_\_\_\_\_

Pain: Location \_\_\_\_\_

Tenesmus \_\_\_\_\_ Bleeding \_\_\_\_\_

Frequent Stools \_\_\_\_\_ Constipation \_\_\_\_\_

Abdominal Pain \_\_\_\_\_ Vomiting \_\_\_\_\_

Loss of Weight \_\_\_\_\_

ASSOCIATED DIAGNOSES \_\_\_\_\_

## ENTRANCE EXAMINATION

PRIMARY TUMOR: Location (\_\_\_\_\_ cm. above anus) \_\_\_\_\_

Size \_\_\_\_\_ Character \_\_\_\_\_

Extent: Annular \_\_\_\_\_ R. Lat \_\_\_\_\_ L. Lat \_\_\_\_\_ Ant \_\_\_\_\_ Post \_\_\_\_\_

Fixation: Post \_\_\_\_\_ R. Lat \_\_\_\_\_ L. Lat \_\_\_\_\_

Involvement: Prostate \_\_\_\_\_ R-V Septum \_\_\_\_\_

Obstruction: Complete \_\_\_\_\_ Partial \_\_\_\_\_ None \_\_\_\_\_

METASTASES: Inguinal Nodes \_\_\_\_\_

Perirectal Nodes \_\_\_\_\_ Liver \_\_\_\_\_

Hemorrhoids \_\_\_\_\_ Distention \_\_\_\_\_

PROCTOSCOPY: \_\_\_\_\_

\_\_\_\_\_

X-RAY EXAM.: Contrast Enema \_\_\_\_\_

\_\_\_\_\_

Chest \_\_\_\_\_ Bones \_\_\_\_\_

SYPHILIS: Serologic Tests \_\_\_\_\_

## TYPE OF TREATMENT WITH DATES

SURGERY: Operator \_\_\_\_\_

1. Combined Abdominal-Perineal (1 or 2 stage) \_\_\_\_\_ 2. Posterior Excision \_\_\_\_\_

3. Abdominal Excision \_\_\_\_\_ 4. Exploratory Laparotomy \_\_\_\_\_

5. Colostomy: Alone \_\_\_\_\_ With Resection \_\_\_\_\_ 6. Miscellaneous \_\_\_\_\_

RADIATION THERAPY: (enter dates only in spaces below) Therapist \_\_\_\_\_

Radium \_\_\_\_\_

X-ray: To Primary \_\_\_\_\_ To Metastases \_\_\_\_\_

OPERATIVE FINDINGS: Location: 1. Above Peritoneum \_\_\_\_\_ 2. Below Peritoneum \_\_\_\_\_

Extent: 1. Mobile \_\_\_\_\_ 2. Fixed \_\_\_\_\_ 3. Adjacent Involvement \_\_\_\_\_

Metastases: 1. None \_\_\_\_\_ 2. Liver \_\_\_\_\_ 3. Regional Nodes \_\_\_\_\_ 4. General Abdominal \_\_\_\_\_

## PATHOLOGICAL EXAMINATION

Biopsy: Date \_\_\_\_\_ Pathologist \_\_\_\_\_ Diagnosis \_\_\_\_\_

Surgical Specimen: Date \_\_\_\_\_ Pathologist \_\_\_\_\_

Gross Examination \_\_\_\_\_

Microscopic Examination \_\_\_\_\_



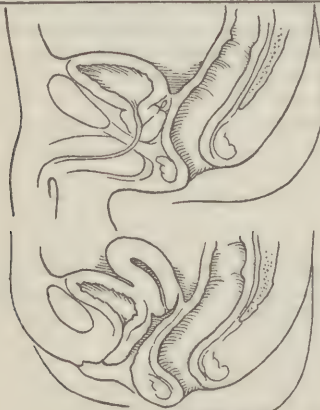
## CANCER RECORD FORMS—CONTINUED

RADIUM ☐ Pre-Operative ☐ Post-Operative ☐ For Recurrence ☐ With X-ray

	Date	Form	Filter	Location	MG or MC	MGH or MCH	Other Units of Dosage
1st Treatment							
2nd Treatment							
3rd Treatment							

X-RAY ☐ Pre-Operative ☐ Post-Operative ☐ With Radium ☐ For Palliation ☐ For Metastases

	Date Begun	Date Ended	KV	Filter	No. Ports	Total Treatments	Alr	TOTAL r	Skin
1st Series									
2nd Series									
3rd Series									



## CLINICAL CLASSIFICATION

(Enter accurate classification on front page, as 1-A, 2-B, 3-C, etc.)

## 1. PRIMARY CASE

- A. Limited to Bowel Wall \_\_\_\_\_  
 B. Local Extension — Mobile Tumor \_\_\_\_\_  
 C. Local Extension — Fixed Tumor \_\_\_\_\_  
 D. Regional Metastases \_\_\_\_\_  
 E. Hepatic Metastases \_\_\_\_\_  
 F. General Abdominal Metastases \_\_\_\_\_

## 2. RECURRENCE POST-OPERATIVE

A \_\_\_\_\_ B \_\_\_\_\_ C \_\_\_\_\_ D \_\_\_\_\_ E \_\_\_\_\_ F \_\_\_\_\_

## 3. RECURRENCE POST-IRRADIATIVE

A \_\_\_\_\_ B \_\_\_\_\_ C \_\_\_\_\_ D \_\_\_\_\_ E \_\_\_\_\_ F \_\_\_\_\_

## 4. RECURRENCE AFTER COMBINED METHODS

A \_\_\_\_\_ B \_\_\_\_\_ C \_\_\_\_\_ D \_\_\_\_\_ E \_\_\_\_\_ F \_\_\_\_\_

## YEARLY FOLLOW-UP

Year	Date	Status	† Status Symbols:
1			A. Operative Fatality
2			B. Alive and Well
3			C. Untraced-Inconclusive
4			D. Alive with Disease
5			E. Died with Disease
6			F. Died without Disease
7			G. Recurrence
8			Local (Original Site)
9			Regional
10			H. Metastases Remote

## ANNUAL FOLLOW-UP NOTES

## FINAL RESULT

Time Since Onset \_\_\_\_\_

Time Since First Treatment \_\_\_\_\_

Autopsy: Yes ☐ No ☐

## ADDENDUM IX. BIBLIOGRAPHY

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## UNITED STATES VETERANS' ADMINISTRATION HOSPITALS

- |                             |                                 |
|-----------------------------|---------------------------------|
| 1. San Fernando, Calif.     | 11. Bath, N. Y.                 |
| 2. San Francisco, Calif.    | 12. Bronx, N. Y.                |
| 3. Los Angeles, Calif.      | 13. Oteen, N. C.                |
| 4. Washington, D. C.        | 14. Dayton, Ohio                |
| 5. Atlanta, Ga.             | 15. Portland, Ore.              |
| 6. Hines, Ill.              | 16. Pittsburgh (Aspinwall), Pa. |
| 7. Indianapolis, Ind.       | 17. Columbia, S. C.             |
| 8. Wadsworth, Kans.         | 18. Memphis, Tenn.              |
| 9. Minneapolis, Minn.       | 19. Kecoughtan, Va.             |
| 10. Jefferson Barracks, Mo. | 20. Wood, Wis.                  |

## VETERANS' ADMINISTRATION HOSPITAL, SAN FERNANDO, CALIF.

(Dr. D. C. Farnsworth, manager; Lt. Col. W. R. Leverton, clinical director)

FEBRUARY 2, 1945.

*General.*—This is a special hospital for tuberculosis patients with an official bed capacity of 394. The physical plant consists of six buildings, two to four stories, and of modern, fireproof construction. The buildings appear to be adequate for the number of patients to be accommodated at present. The equipment in all departments seems to be sufficient for good diagnosis and treatment and is of good quality.

The hospital is administered by a manager, who is a physician, assisted by a clinical director. Members of the medical staff are on either United States Army Medical Corps or United States Civil Service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 14 active and 1 Dental Corps member is organized on the closed plan, the clinical director acting as chief of staff. There is basic departmentalization, with departmental heads who are active in control of the clinical work. There is a consulting staff of two members, one of whom is an outstanding lung-tumor surgeon and the other a qualified anesthetist, both from Los Angeles. The surgeon is on part-time, salary basis, the anesthetist on fee basis. There are no residents or interns in the hospital at present.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The program for the meetings consists of consideration of clinical cases and deaths, prepared papers on a medical sub-



ject and sometimes administrative matters. Special clinicopathological conferences are held twice monthly. These meetings are attended regularly by the pathologist and radiologist and appear to afford an adequate review of the clinical work. Minutes and attendance records of the general staff meetings are kept in the office of the clinical director.

*Medical records.*—The medical records are prepared by the staff medical officers and appear to be complete in all details. A full-time trained librarian, who is assisted by a corps of trained clerks, has charge of the completed records. The records are filed by serial number, recognized nomenclatures are used, and cross-indexing according to disease and operation is up to date. The cross-indexes are used to some extent by the medical staff for group studies and other résumés of the clinical work.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped clinical and surgical pathological laboratories, in which all types of laboratory procedures are carried out. The part-time pathologist, Maj. J. L. Bailey, is qualified by training and experience, and spends about half-time in the department. He is assisted by two full-time, registered technicians. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The full-time roentgenologist, Dr. J. E. Damron, is qualified by training and experience. There is one full-time, trained technician in the department.

The facilities for physical therapy are limited, due to the fact that physical therapy is little used in the treatment of tuberculosis patients. The facilities are supervised by the roentgenologist and two full-time, trained technicians are employed. Complete records of treatments are maintained in the department.

Other adjunct facilities, such as basal metabolic and electrocardiographic apparatus, and occupational therapy, are provided and all are competently supervised.

*Surgical department.*—The facilities for surgery consist of one major and one minor operating room, one eye, ear, nose, and throat operating room, sterilizing and workrooms. The various rooms are situated for the greatest convenience and appear to be adequate in extent for the present needs of the hospital. The supply of surgical instruments seems to be sufficient for any operation usually performed in an institution of this type. Two graduate nurses and two orderlies are assigned to the surgical department.

The general, thoracic, and any orthopedic or urological surgery, is done by the chief of the department, Maj. J. B. Chandler; lung tumor surgery is done by the consultant, Dr. F. F. Dolley, as noted above. There is a separate surgical division of ophthalmology-otolaryngology, staffed by the chief of division, Maj. L. C. Hobson, who does all the surgery in that combined specialty.

The chief of surgery and the chief of the division of ophthalmology-otolaryngology are responsible, through the manager and the clinical director, to the medical director of the Veterans' Administration for all surgery done in the department. Other means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered by members of the medical staff and are supervised by the pathologist, Maj. J. L. Bailey. The usual types of anesthesia are used, including cyclopropane and pentothal sodium; special records are made of anesthetics administered and there are some postanesthetic notations recorded. Full recording of the physical examination, diagnostic laboratory procedures and the provisional diagnosis is required before the administration of an anesthetic may begin.

Any infection occurring postoperatively in a clean surgical case is recorded in the office of the chief of surgery, following which the incident is investigated, every attempt made to locate the source of infection, and appropriate corrective measures are taken.

During the year 1944 there were 267 major and 509 minor operations performed in the hospital, and in addition, 6,651 pneumothorax and pneumoperitoneum procedures. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available. Since there are no residents in the hospital, a statement as to how many operations will be done by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies are established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Adult male and female patients are admitted for the medical and surgical treatment of tuberculosis. The admission of patients is limited, in a general way, to those with tuberculosis, although occasionally an emergency patient with a nontuberculosis condition may be admitted. There are 23 beds allotted for thoracic surgery and 30 beds for female patients. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1944 the average daily census in the hospital was 310. There were 593 regular admissions and 402 regular discharges, and, in addition, 235 temporary admissions and 229 temporary discharges. The patients listed as being on temporary status were either in for diagnosis or in transit to other veterans' facilities. An exact division of patients admitted or discharged into clinical services is not available due to the fact that patients are admitted through the reception out-patient department to the diagnostic service and thoroughly worked up before the diagnosis is announced. However, an approximate division shows the following as surgical patients: 81 in general surgery, 256 in thoracic surgery, 10 in orthopedic surgery, 4 in ophthalmology, and 19 in otolaryngology, and 6,057 pneumothorax and pneumoperitoneum refills were administered.

In the out-patient department during 1944, for purely out-patient purposes, there were 1,226 patient visits, of which almost half were for pneumothorax and pneumoperitoneum refills.

Autopsies during 1944 were 19 out of 72, or 26 percent. Complete protocols are on file in the clinical laboratories for all autopsies performed.

*Obstetrics.*—The hospital does not maintain an obstetrical department.

*Out-patient department.*—A member of the full-time medical staff is in charge as chief of the out-patient and reception service. Activities in the department are limited to the examination and treatment of patients with tuberculosis and examinations for rating purposes. Patients are admitted in the usual out-patient sense and for rating purposes from 8:30 a. m. until 4:30 p. m., daily except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—The hospital pharmacy is under the supervision of a full-time registered pharmacist. Only pharmaceutical preparations of standard quality are used. Complete records of drug stock and prescriptions are maintained, and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 39 graduate nurses on duty at the time of survey, 12 of whom are in supervisory capacity, and 27 general duty nurses, allowing a nurse-patient ratio of about 1 to 8. Conferences of the entire nursing staff are held irregularly, but on an average of once each month, for the consideration of administrative and other matters. The nurses are housed in a home that is of fireproof construction.

There are, in addition to the graduate nurses, 45 subsidiary workers who are active in the care of patients in the hospital.

*Dietary department.*—Three dietitians are employed in the organized dietary department of the hospital. All are graduates of approved schools, and one of the assistants is a member of the American Dietetic Association. Members of the department are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—There is not a department of medical social service in the hospital.

*Library.*—The hospital has a medical library of 225 current, standard texts, and receives 17 medical periodicals monthly. A part-time librarian is in charge of the medical library.

*Residencies.*—Plans have not been drawn up for graduate-training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—This hospital may be said to present fair possibilities as a center for graduate training in thoracic surgery, inasmuch as the clinical material in admissions and the volume of surgery done appear to justify consideration of a program. Out-patient material in an institution of this nature is, necessarily,



sharply limited, and it is not probable that such material will be greatly increased in the future.

The points of importance which should have consideration in connection with the establishment of a graduate-training program in this institution are: A qualified pathologist in charge of the clinical laboratory, and a qualified roentgenologist in charge of the X-ray department. Additional technical help should be provided in those departments when possible. Although the autopsy percentage was 26 percent during 1944, it should be raised to as near 50 percent as possible at least, as recommended by the college where graduate-training programs are established or under consideration.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*

VETERANS' ADMINISTRATION HOSPITAL, SAN FRANCISCO, CALIF.

(Col. Jas. G. Donnelly, manager; Dr. Rembert J. Coney, chief medical officer)

FEBRUARY 6, 1945.

*General.*—This is a general hospital with an official bed capacity of 448. The physical plant consists of a six-story and basement, modern, fireproof building. The building appears to be adequate for present needs, although 315 additional beds for veteran care are contracted for in nearby Army, Navy, and Marine hospitals. At the time of survey only 288 of the 448 beds in the hospital were in use, due to a shortage of nursing and subsidiary personnel. It was anticipated, however, that additional beds would be utilized as more nursing personnel became available. The equipment in all departments appear to be adequate and is of good quality.

The hospital is administered by a manager who is a physician assisted by a chief medical officer. Members of the medical staff are on either United States Army Medical Corps or United States Civil Service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 39 active and 3 Dental Corps members is organized on the closed plan, the chief medical officer acting as chief of staff. There is basic departmentalization, with department heads who are active in control of the clinical work. There is a consulting staff of 35 members, comprising an outstanding group of clinicians and teachers of the two medical schools in San Francisco and representing all of the medical and surgical specialties. Some members of this group are on a part-time salary basis and visit the hospital regularly, while others are on a fee basis and are called at the need arises. At present there are no residents or interns in the hospital.

The medical staff meets regularly, every 2 weeks throughout the year, for a review of the clinical work of the hospital. Alternate meetings are of the nature of clinicopathological conferences, in which deaths and autopsy material receive special attention. These meetings appear to afford an adequate review of the clinical work and are regularly attended by the pathologist and radiologists. Minutes and attendance records of the meetings have not been kept since the hospital resumed full activity in December 1943.

*Medical records.*—The medical records are prepared by the staff medical officers and appear to be complete in all details. A full-time, trained librarian has charge of the completed records. She is assisted by a corps of trained clerks. The records are filed by serial number, recognized nomenclatures are used, and cross-indexing according to disease and operation is up to date. The cross-indexes are used to some extent by the medical staff for group studies.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped clinical and surgical pathological laboratories, in which all types of laboratory procedures are carried out. The space allotted to the department is, however, entirely inadequate to carry on efficient work. It is probable that arrangement of available space in the hospital will allow expansion of the allotted space. The part-time pathologist, Dr. John J. Hawthorne, is qualified by training and experience, and spends a total of 6 hours a week in the department. He is assisted by a small corps of trained technicians. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The full-time roentgenologist, Capt. George J. Hepner, and his full-time assistant, Maj. N. B. Beaver, are qualified by training and experience. A small group of trained, full-time technicians is employed.



There are complete facilities for physical therapy in the hospital, supervised by Capt. E. R. Movitt, a member of the staff of the department of medicine. Three full-time, trained technicians are employed, and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of three major operating rooms, a plaster room, a cystoscopic room in the roentgenological department, sterilizing and work rooms. The various rooms are situated for the greatest convenience and appear to be adequate in extent for the present size of the hospital. The supply of instruments seems to be sufficient for any type of operation. Three graduate nurses and two orderlies are assigned to the department.

The full-time general surgical staff consists of five members, supervised by the chief of surgery. Much of the general, orthopedic and urological surgery is done by members of the full-time staff without much specialization, and the smaller portion of work in those divisions is done by specialists of the consulting staff. Specialized surgery, such as thoracic and neurological surgery, is done entirely by members of the consulting staff.

There is a separate surgical division of ophthalmology-otolaryngology, staffed by a chief of division and one assistant. Probably a majority of surgery in this specialty is done by the chief of division, the lesser amount by members of the consulting staff.

The chief of surgery is responsible, through the manager and chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in his department, and the chief of ophthalmology-otolaryngology is likewise responsible for surgery in his division; other members of the general surgical and specialty divisions necessarily share in their responsibility, however. Other means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording of physical examination, diagnostic laboratory findings, and the provisional diagnosis.

Anesthetics in the department are administered by members of the surgical staff and are supervised by Lt. Harold Hanzlik. All types of anesthesia are used, including cyclopropane, avertin, and sodium pentothal; special records are made of anesthetics administered and there are some postanesthetic notations recorded. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

Infections occurring postoperatively in clean surgical cases are recorded in patients' medical records, whereas there should be a complete, centralized record of these infections in the office of the chief of surgery or elsewhere in the hospital.

During the year 1944 there were 570 major and 692 minor operations done in the hospital. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available. Since there are no residents in the hospital, a statement as to how many operations will be done by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies are established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Adult male patients are admitted in all general branches of medicine and surgery, but female patients are admitted only for emergency conditions at present. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. While there are no beds allotted to the various classes of surgical patients, at present, 109 beds are reserved for all surgical patients. Patients are not classified as either free or paying but all are available and may be utilized for teaching purposes.

During 1944 the average daily census in the hospital was 211 and 1,626 patients were discharged. An exact division of patients discharged into clinical services is not available due to the fact that patients are admitted through the reception out-patient department to the diagnostic service and thoroughly worked up before the diagnosis is announced. However, an approximate division shows the following as surgical patients: 239 in general surgery, 34 in ophthalmology, 77 in otolaryngology, 116 in urology, 107 in orthopedics, 32 in

neurosurgery, 2 in plastic, and 18 in proctology. There were 58 acute fractures treated during the year.

In the out-patient department during 1944, for purely out-patient purposes, 5,481 patients were given 11,350 examinations and treatments, of a total 39,932 patient visits for both out-patient and rating purposes.

Autopsies during 1944 were 43 to 224, or 19 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—The hospital does not maintain an obstetrical service.

*Out-patient department.*—A member of the full-time medical staff is in charge as chief of the out-patient and reception service, and 20 other members of the medical staff are on full-time assignment to the department. The fact that more than half of the full-time medical staff is on duty in the department is due to the huge backlog of patients for examination that has accumulated during the partial closing of the hospital and since that time. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8:30 a. m. until 4:30 p. m. daily, except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and filed in the hospital. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—The hospital pharmacy is under the supervision of a full-time, registered pharmacist. Only pharmaceutical preparations of standard quality are used. Complete records of drug stock and prescriptions are maintained, and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 43 graduate nurses on duty at the time of survey, 16 of whom were in supervisory capacity, and 27 general duty nurses, allowing a nurse-patient ratio of about 1 to 5. Conferences of the entire nursing staff are held regularly, twice monthly, for the consideration of administrative and other matters. The nurses are housed in a home that is of the same construction as the hospital building.

There are, in addition to the graduate nurses, 49 subsidiary workers who are active in the care of patients in the hospital.

As noted elsewhere, 160 beds in the hospital were unoccupied at the time of survey due to a shortage of nurses and subsidiary workers. It was expected at that time that an additional 5 graduate nurses and 56 Army enlisted men, the latter to act as orderlies, would report within a few days, which would allow some of the unoccupied beds to be put into active use.

*Dietary department.*—There is an organized dietary department in the hospital. Three dietitians are employed, all of whom are graduates of approved schools of dietetics and the chief of the department and one assistant are members of the American Dietetic Association. Members of the department are active in consultation with staff physicians in the planning and preparation of special diets for patients whose medical records are always available for examination in connection with that purpose. The hospital kitchens, refrigerators, and supply rooms were visited and found to be in sanitary condition.

*Medical social-service department.* A full-time, trained directress has charge of the medical social-service department, and two additional trained workers are employed. Social and financial investigations are made of patients when indicated, chiefly through interviews with patients and visiting relatives, and full reports of these investigations are on file in the patients' medical records and in the department. Follow-up work on patients is not undertaken, due to the widely scattered sources from which patients are drawn and the small size of the departmental staff.

*Library.*—The hospital has a medical library of 321 current, standard texts and receives 30 medical periodicals monthly. A full-time librarian is in charge of the library.

*Residencies.*—Plans have not been drawn up for graduate-training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—This hospital may be said to present limited possibilities as a center for graduate training in general surgery at present. However, the foregoing report does not give a true picture of the possibilities when it is considered that the hospital was all but closed for about 2 years prior to December 1943, and that the clinical work has been building up gradually since the latter date. At the time of survey, there were 160 beds not in use in the hospital, and 315 beds are under contract for veteran patients in Army, Navy, and marine hospitals in the nearby vicinity. When circumstances will permit all of the beds in the



hospital to be actively occupied, the hospital will, without a doubt, have sufficient clinical material to justify the establishment of a program of graduate training in surgery, if not one or more of the surgical specialties. There may be, by the same token, a moderate increase in the out-patient patronage, which will add to the available clinical material.

As pointed out above, more than half of the full-time medical staff is occupied with examination in the out-patient reception department. It is probable that, as the large number of patients for examination is reduced, this division of the medical staff will equalize itself in order that an increased number of patients in the hospital may be properly cared for.

Other considerations with regard to the medical staff which should receive attention in connection with the establishment of graduate-training programs are: a qualified pathologist who would devote more time to the department than at present; a full-time, qualified roentgenologist; additional general staff meetings, and/or clinicopathological conferences, as well as departmental meetings at frequent intervals when the size of the staff warrants it. There should be a substantial increase in the autopsy percentage.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys*

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VETERANS' ADMINISTRATION HOSPITAL, LOS ANGELES, CALIF.

(Col. Charles F. Bayer, Medical Corps, chief medical officer;  
Col. R. A. Bringham, manager)

JANUARY 29, 1945.

*General.*—This is a general hospital with an official bed capacity of 1,080. The physical plant consists of a six-storied and partial basement, modern, fireproof building. At the time of survey 104 beds were not in use due to a shortage of graduate nurses and subsidiary workers. It was anticipated, however, that these beds would be utilized as additional nursing and subsidiary personnel became available. The hospital furnishes care for acute surgical and medical conditions, as well as out-patient service, to residents of the nearby soldiers' home (for both male and female patients), which has a bed capacity of about 3,000 and an average daily census of about the same figure. The equipment in all departments of the hospital appears to be adequate for efficient diagnosis and treatment, and is of good quality.

The hospital is administered by a manager who is a layman, assisted by the chief medical officer and a clinical director. Members of the medical staff are on either United States Army Medical Corps or United States civil-service status and are assigned to this hospital by the medical director of the Veterans' Administration; consultants are appointed by the medical director on recommendation of the manager and the chief medical officer. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff consisting of 69 active, 6 dental corps, and 16 supernumerary officers transferred to this facility for assignment, is organized on the closed plan, the clinical director acting as chief of staff under supervision of the chief medical officer. The staff is extensively departmentalized with heads of departments who are active in control of the clinical work. The consulting staff of eight members is made up of outstanding specialists, chiefly in general surgery and the surgical specialties, practicing in Los Angeles and vicinity; some members of the group are on part-time salary basis and visit the hospital regularly, while others are on fee basis and are called as the need arises.

The medical staff meets each week throughout the year for a review of the clinical work of the hospital. The program consists of consideration of clinical cases, deaths, autopsy material, and sometimes staff or outside speakers on medical subjects. In addition, over-all departmental meetings in medicine and surgery, and journal club meetings for review of current literature, are held weekly throughout the year. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologists and radiologists; only about 50 percent attendance on the part of the active medical staff was recorded for the year 1944, however. Minutes of the general staff meetings and attendance records are kept. Clinicopathological conferences are not held.

The hospital has no interns or residents at this time.



*Medical records.*—A full-time, trained librarian has charge of the completed medical records, assisted by a large corps of trained clerks. The records are prepared by the staff officers and appear to be complete in essential details. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease is up to date. The cross-indexes, as far as developed are said to be but little used by the staff physicians for making group studies or other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has well organized and fully equipped clinical and surgical pathological laboratories in which all of the usual types of laboratory procedures are carried out. The full-time pathologist, Maj. H. C. Fortner, is qualified by training and experience, and holds membership in a national pathological society. His full-time assistant, Capt. L. M. Hunter, has had training and experience. Eight full-time, trained technicians, of whom two are registered, are employed. All tissues removed at operation are examined and full reports rendered.

The radiological department is well equipped, with radiographic, fluoroscopic, superficial and deep therapeutic, and mobile units, and 120 milligrams of radium are available for use. It was stated that a new 400-kilovolt Keleket therapy unit had been shipped and would be installed in the hospital when received, which was expected to be soon. Previously the highest voltage apparatus available for treatment had been 220 kilovolts. The full-time radiologist, Maj. C. G. Lyons, is a diplomate in roentgenology, while his full-time assistant, Maj. W. A. Gore, is qualified by training and experience. Eight full-time technicians, of whom one is registered, are employed.

The facilities for physical therapy in the hospital are complete and are supervised by Lt. Col. Norman E. Titus, the full-time chief of physical medicine. Ten full-time, trained technicians are employed, two of them registered. Complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major and one minor operating rooms, a fracture room, one cystoscopic room, one major room for ophthalmology-otolaryngology, sterilizing and work rooms. The various rooms are conveniently situated and are said by the surgical staff to be adequate for their needs. The supply of surgical instruments is extensive in number and variety and appears to be sufficient for any type of operation ordinarily performed in the hospital. Four graduate nurses, of whom one is supervisor, and five orderlies are assigned to the department.

The full-time staff in general surgery and the allied specialties consists of eight members, supervised by the chief of department. The chief and three assistants do all major general surgery; major orthopedic operations are performed by a member of the general surgical group and an orthopedist, while a sixth member of the surgical group does the minor orthopedic operations. A full-time urologist and a tumor surgeon, who perform operations in those specialties, complete the surgical group. Of the four members of the separate division of ophthalmology-otolaryngology, the chief and one assistant share operations in the specialty between them. It would appear that the surgeons of the consulting group are seldom, if ever, employed as far as the actual performance of operations is concerned.

The chiefs of surgery and ophthalmology-otolaryngology are responsible, through the manager, chief medical officer, and clinical director, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in their responsibility, however. Additional means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by physicians, supervised by Maj. Harold D. Spickerman, the tumor surgeon. The usual types of anesthesia are used with the exception of nitrous oxide, including cyclopropane, ethylene, pentothal sodium, and avertin. Special record forms are used for recording the details of anesthetics but follow-up notations were not noted during examination of the medical records. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

Infections occurring postoperatively in clean surgical cases are said to be recorded in a book on each of the surgical wards, but a central record in the

office of the medical director or chief of surgery, or elsewhere in the hospital, showing the total number of infections occurring in the hospital, is not kept. It is probable that maintenance of a central record would act as a stimulus to reducing the number of infections to a minimum.

During the year 1944 there were 746 major and 1,580 minor operations performed in the hospital. It was stated that only emergency surgery was done during 1944 and thus far in 1945, due to the shortage of graduate nurses and that a huge backlog of elective surgery is piling up. In normal times the number of elective and emergency operations will average from 3,000 to 3,500. Records as to the nature of the operations performed, collectively, or their division into general and specialized surgery, were not available for review due to the fact that an operative cross-index is not maintained in the medical records department. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery, while the treatment of female patients is limited to emergency conditions at present. Facilities are not provided for the care of patients with communicable diseases but ample means for segregation and isolation make their treatment possible when the need arises. There are 44 beds allotted to clean general surgery, 62 to aseptic general surgery, 30 to women, including gynecology, 35 to urology, 28 to ophthalmology-otolaryngology, 62 to orthopedic surgery, 123 to tumor surgery, and 35 to neurosurgery. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1944 the average daily census in the hospital was 1,064 and 8,397 patients were admitted. An exact division of patients admitted into clinical services is not available, due to the fact that admissions are through the reception service and cases are thoroughly worked up before the diagnosis is announced. An approximation indicates that the following were surgical patients: 1,168 in general surgery; 22 in plastic surgery; 261 in proctology; 120 in neurological surgery; 544 in orthopedic surgery; 515 in urological surgery; 30 in gynecology; 172 in ophthalmology; and 344 in otolaryngology. In addition, 294 acute fractures were admitted, with 11 open reductions and 1 postoperative infection among them.

In the out-patient department during 1944 a total of 99,000 treatments were administered to 18,000 patients, and 7,200 patients submitted to 15,000 examinations, the latter including examinations for rating purposes.

Autopsies during 1944 were 352/897 or 39 percent. Complete protocols are on file in the surgical pathological laboratories for all autopsies performed.

*Obstetrics.*—An obstetrical department is not maintained in the hospital.

*Out-patient department.*—The out-patient department functions separately from the reception service and is staffed by a chief and 17 assistants. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8 a. m. until 5 p. m., daily except Sunday. Complete records of patient visits, physical findings and treatments administered, as well as the physical findings for rating purposes, are filed in the department. The appointment system is employed as a means of follow-up on patients.

*Pharmacy.*—A full-time, registered pharmacist has charge of the hospital pharmacy. All pharmaceutical preparations used are of standard quality. Complete records are maintained of drug stock and prescriptions, and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing service is supervised by a full-time directress of nursing. There was a staff of 122 graduate nurses on duty at the time of survey, 12 of whom were in supervisory capacity and 110 on general duty, allowing a nurse-patient ratio of about 1 to 8½. Conferences of the nursing staff are held on call, averaging monthly, for the consideration of administrative and other business. A training school for cadet nurses in their last 6 months of training is conducted in the hospital, with faculty and facilities for instruction, and 4 pupils were in training at the time of survey. The nurses occupy homes, of which one is fireproof and the other nonfireproof.

In addition to the graduate and cadet nurses, 255 subsidiary workers are employed who are active in the care of patients in the hospital.



As noted elsewhere in this résumé, 104 beds in the hospital were unoccupied at the time of survey due to a shortage of nurses and subsidiary workers. It was expected that the beds would be put into use as the necessary graduate nurses and subsidiary workers became available.

*Dietary department.*—Eleven dietitians are employed in the organized dietary department of the hospital. All are graduates of approved schools and the chief and three assistants are members of the American Dietetic Association. Members of the staff are active in consultation with medical officers in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—A qualified directress and five full-time, trained assistants are employed in the department of medical social service. Social and financial investigations are made when indicated and full reports are on file in the patients' medical records and in the department. Discharged patients are followed up through the media of home visits, mail, and telephone.

*Library.*—The medical library consists of 465 current, standard texts and 38 medical periodicals are received monthly. A full-time librarian is in charge of the library.

*Residencies.*—Programs have not been drawn up for graduate training in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—This institution appears to present excellent possibilities as a center for graduate training in surgery, inasmuch as the quantity of clinical material available and the volume of surgery done are adequate for that purpose. It will be noted that only emergency surgery was done during 1944 and that the volume of surgery in normal times would be at least 40 percent of the volume reported for that year. A classified list of operations performed could not be secured, but it is probable that a good variety of operations and resulting surgical tissues would be available in normal times for resident training due to the fact that the age span of male patients, at least, is being constantly widened by the admission of veterans of World War II. It is probable that basic science instruction in pathology could be given in the hospital and that an affiliation with a medical school would provide for the other basic sciences for which facilities are not available in the hospital. The medical and surgical staffs are well organized for control of the clinical work, conducting a program of graduate training in general surgery and the instruction of residents. The chiefs of surgery and ophthalmology-otolaryngology and the consultants in general surgery, urological surgery, ophthalmology-otolaryngology and tumor surgery are Fellows of the American College of Surgeons.

The following points are of importance if the establishment of graduate training programs in this hospital are considered: The percentage of attendance at the weekly meetings of the general medical staff; the fact that clinico-pathological conferences are not held, especially so since a large number of autopsies is performed; cross-indexing of the medical records according to operation has not been developed for use by the medical staff and the possible future residents; the qualifications of the pathologists and radiologists should have further consideration; a centralized record of infections occurring postoperatively in clean surgical cases is not maintained. It is the recommendation of the American College of Surgeons that, in institutions where programs of graduate training in surgery are functioning or are contemplated, the incidence of autopsies be at least 50 percent and as much more as possible. In addition to the foregoing, the comparatively high nurse-patient ratio is of importance in the field of hospital standardization.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*

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VETERANS' ADMINISTRATION HOSPITAL, WASHINGTON, D. C.

(Col. Lewis G. Beardsley, manager; Dr. Grady O. Haynes, chief medical officer)

FEBRUARY 6, 1945.

*General.*—This is a general hospital with an official bed capacity of 327 and there were 295 patients in the hospital at the time of survey. The physical plant consists of a central four-storied, fireproof, modern building with four adjoining two-storied buildings, all connected by a corridor. Two of the adjacent buildings,



formerly used as dormitories for a girls' school, have been converted into wards for patients. One of the buildings is designated as a clinic building which contains the laboratory, X-ray department, eye, ear, nose, and throat examining and operating rooms, and the physiotherapy service. There are eight designated ward divisions in the hospital: Building A, respiratory diseases and diagnosis; building B, reception center and eye, ear, nose, and throat examining and treatment rooms; building C, general medical and surgical service for Negro patients; building D, medical patients; building G is assigned to the tumor service. The first floor in the main building is assigned to neurological surgery, the second floor to general surgery and the surgical specialties while the third floor is occupied by female and general medical cases.

The hospital is well equipped in all departments for diagnosis and the treatment of patients, but the physical plant is in need of repair and better maintenance, particularly the three ward buildings which should either be extensively rehabilitated or replaced.

*Medical staff.*—The hospital is administered by a manager who is a lieutenant colonel of the Medical Corps of the United States Army, assisted by a chief medical officer who is responsible for direction of the clinical services. There are 29 medical officers assigned to this hospital. Four members of the staff were selected by the Veterans' Administration through United States Civil Service and the remainder are commissioned officers in the Medical Corps of the United States Army and assigned to duty at the hospital. The medical staff is organized under the closed plan and all the officers are on full-time basis.

The following clinical divisions have been established: The reception outpatient center with 8 medical officers; surgical service, including the surgical specialties, with 8 medical officers; general medical service with 7 medical officers; the urological service with 2 officers; the clinical laboratory with a pathologist in charge, and the X-ray department with 1 radiologist in charge. In addition to this group there are 2 full-time dental officers, and a roster of 24 consultants on part-time basis. A large number of the consultants are not active at this time; some have gone into the armed forces, others have declined to come to the hospital regularly, and 2 or 3 have practically retired. However, about 15 of the consulting specialists will come to the hospital as often as needed. The number of medical officers assigned to this hospital is considered adequate to carry on the professional work.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The programs consist of consideration of at least two selected cases treated in the hospital, sometimes a medical topic is discussed by one of the staff, and the various departments provide the program in rotation. The meetings are held from 1 to 2 p. m. on Saturdays and the average attendance has been about 22, while there are 29 members on the staff. Records of the meetings consist only of an announcement of the programs to be carried out and there are no regular minutes or abstracted case reports for review. There are no departmental meetings or clinicopathological conferences, although reports of deaths and autopsies may be taken up at the regular weekly meeting.

As there are no departmental meetings or clinicopathological conferences of the medical staff, it would seem that the one weekly general meeting has reduced the conferences for clinical review to a minimum.

*Medical records.*—The medical officers write the clinical records, which are generally acceptable in the component parts. The medical record department is well organized under the direction of a trained librarian who is assisted by two full-time, and one part-time, clerks. Patients' charts are filed by serial number and the final diagnosis is recorded in compliance with the nomenclature used by the Veterans' Administration. Cross-indexing according to disease and operation has not been developed and there is no indication of the medical records being used for group studies.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped clinical and surgical pathological laboratories in which all types of laboratory procedures are carried out. The full-time pathologist, Maj. Carmelo De Angelis, is said to be well qualified in clinical and tissue pathology. He is assisted by a staff of 5 trained technicians. This department is said to be doing a large number of examinations, but the annual report for 1944 was not available for review. There were 3,417 tissues examined last year, and 65 autopsies were reported, which represents 22 percent of deaths in the hospital.

The radiological department is supplied with modern radiographic, fluoroscopic, and therapeutic apparatus. The therapy department has a 200-kilovolt unit and 100 milligrams of radium. Maj. Solomon Bersack, the full-time radiologist, is said to be well qualified in X-ray diagnosis and therapy. The technical staff

consists of three well-trained technicians. Reports of examinations are written in duplicate, one copy being filed with the patient's chart and the other in the department. Only monthly summaries of the work done are available for review as annual reports are not prepared.

The physiotherapy department is completely equipped except for mechanotherapy and is under the direction of Captain Weinberg of the orthopedic staff. Three full-time, trained technicians are employed. About 2,300 treatments are given each month to an average of about 100 to 150 patients. Complete records of treatments are kept; one copy is filed in the department and the other in the patient's chart.

*Surgical department.*—The facilities for surgery consist of two major operating rooms and a cystoscopic room. The treatment rooms of the eye, ear, nose, and throat department are in ward D, in the reception center, where a considerable amount of the more minor surgery in ophthalmology-otolaryngology is done. The main operating rooms are located on the fourth floor of the main building, just above the floor occupied by the surgical wards.

The department appears to be well equipped for most all types of operations. There are three graduate nurses who are responsible for the operating room service, assisted by two or three orderlies. A medical assistant is employed in all major operations. Evidence of preoperative study and a provisional diagnosis are recorded prior to all operations. The findings and technique of operations are well described on the patient's charts and signed by the surgeons. All infections of clean surgical wounds are recorded and thoroughly investigated according to regulation. Consultations are frequent as members of the surgical staff work closely together every day on the wards and are familiar with all cases under treatment.

The full-time staff in general surgery and the surgical specialties consists of eight members who are under the supervision of the chief of surgery and heads of the specialty divisions. There is a separate division for ophthalmology and otolaryngology which is staffed by a chief of division and one assistant. The chief of surgery is responsible, through the chief medical officer and the manager, to the Medical Director for all surgery done in his department and the chief of ophthalmology-otolaryngology likewise is responsible for the surgery done in his division. All surgery is done by the chief of department or by assistants who he considers competent to do the operation. Additional means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed staff organization and complete preoperative recording, including consultation.

A medical anesthetist has not been appointed as chief of the anesthetic service. All anesthetics are administered by staff physicians and consist of ether, nitrous oxide, local, spinal, cyclopropane, and to some extent, ethylene. Complete reports of physician examination and urinalysis are recorded before all operations. Special record forms for anesthetics are not used and the reports of anesthetics consequently are incomplete.

The number of operations reported was 310 majors and 375 minors. The classification of operations was approximately as follows: Proctology, 102; thoracic surgery, 28 major and 238 minor operations; neurological surgery, 53; orthopedics, 88 (35 open reductions, 53 closed reductions); urological surgery, 64 major, 308 minor; gynecological surgery, 23; ophthalmology, 43; otolaryngology, 103; general surgery, 310 majors and 375 minors; plastic surgery, 10. There were also 138 cystoscopic examinations and ureterograms.

*Clinical material.*—During the year 1944 there were 3,983 patients admitted to this hospital, of which about 1,500 were assigned to general surgery and the surgical specialties. The hospital does not keep a classified record of surgical patients, which makes it impossible to determine how many patients were assigned to each service.

All general surgical patients and a limited number of orthopedic cases are kept on 1 floor of the main building where there are 71 beds. At the time of the survey, there were 67 patients on this service. There are also some surgical patients on the B ward, used by the tumor service, and a few gynecological and surgical cases on the women's ward which has an average census of about 20 patients. The volume of surgery is not large, but there is a fairly good variety due to the various types of cases admitted, which include those assigned to the specially organized tumor service. There are some diagnostic, neurological, and chest cases which are veterans of World War I, also some veterans of the present World War are among those admitted.

The hospital was designated as a diagnostic center about 15 years ago. Problem cases, for diagnosis and adjustment of compensation, were referred by other hos-



pitals for thorough study by a specially selected group. In 1932 there were 1,738 problem cases studied in the hospital, whose average stay was about 15 days. The number of cases dropped 100 to 200 a year to an all-time low in 1944, when only 278 diagnostic cases were admitted. However, cases for routine treatment have increased until the census today is sufficient almost to fill the hospital. Of 295 patients in the hospital today, 10 are for diagnosis and about 60 are the chronic or custodial type, leaving about 225 routine treatment cases. Therefore, the picture from the clinical standpoint has changed radically in this hospital, from a diagnostic center to a routine treatment hospital.

The institution is especially designated as a center for the following services: Diagnostic center, neurological and neurosurgical for the southeastern section of the United States, tumor service for North Carolina, Virginia, parts of West Virginia and Tennessee and all of Maryland, chest surgery center except for pulmonary tuberculosis, and, finally, any problem cases.

*Obstetrics.*—This hospital does not provide an obstetrical service.

*Out-patient department.*—There is an organized out-patient department in the hospital representing all usual staff services. It is under the chief of department who is on full-time basis.

*Pharmacy.*—The hospital pharmacy is under the supervision of a full-time, registered pharmacist. Usually there are two assistants, but at the present time there is only one. Complete reports of drug stock and prescriptions are maintained, and narcotic records are checked regularly by the pharmacist.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There were 49 graduate nurses on duty at the time of the survey, of which 5 were in supervisory capacity. There are also cadet nurses in training, and there are 44 attendants assigned to assist in the care of patients on the wards. Because of the shortage of attendants, 12 enlisted men of the Army have been assigned here to help with the ward work. Conferences of the entire staff of nurses are held at irregular intervals for the consideration of administrative matters. The well-furnished comfortable nurses' home, situated near the hospital, is adequate for the graduate staff.

*Dietary department.*—The hospital has an organized department of dietetics. In addition to the chief dietitian, who is a graduate, registered dietitian, there are two assistants who have had training in this work. The dietitians are active in consultation with staff physicians in planning special diets for patients, whose medical records are available for examination in connection with that purpose.

*Medical social service department.*—This department is under the direction of a full-time, trained medical social worker who has, usually, one assistant, but the latter position is vacant at the present time. Investigation of social conditions of patients are made where indicated, and full reports of these investigations are on file in the department. Follow-up of discharged patients is conducted to some extent through home visits, mail, and telephone.

*Library.*—The hospital has a medical library of 25 current periodicals and 484 standard textbooks. A librarian is in charge of this department, which is open throughout the day.

*Residencies.*—There are no interns in the hospital and plans have not been made for establishing a program of graduate training in general surgery or the surgical specialties.

*Conclusions.*—1. A fully equipped laboratory, with a well-qualified pathologist in charge, is maintained in the hospital. The histopathological material available for study would be the tissues from about 65 autopsies, 414 major operations and 921 minor operations annually. The laboratory also does a considerable number of chemical, bacteriological, and serological procedures. An annual report of laboratory examinations is not made, hence it was impossible to get definite statistics on the above. However, a fairly good variety of material is sent to the laboratory, and it would seem that a resident of surgery could spend 4 to 6 months in the laboratory to good advantage.

2. The active X-ray service could probably give a resident fairly adequate instruction in that specialty.

3. The tumor clinic, which meets weekly and admits approximately 160 new patients each year, would be available for the instruction of residents.

4. There are no facilities here for anatomical dissection or courses in surgical anatomy.

5. The lack of a cross-index of diseases and operations in the medical record department makes it impossible for the hospital to supply a complete list of major operations.

E. W. WILLIAMSON, M. D.,  
Assistant Director.



## VETERANS' ADMINISTRATION HOSPITAL, ATLANTA, GA.

(Dr. Roy H. Bryant, chief medical officer; Mr. J. M. Slaton, Jr., manager)

APRIL 24, 1944.

*General.*—This is a general hospital, with an official bed capacity of 317, although 415 beds were set up and ready for use on the date of survey. The physical plant consists of a four-story and partial basement, modern, fireproof building. The equipment in all departments appears to be adequate for good diagnosis and the care of patients, and is of good quality.

The hospital is administered by a manager, who is a layman, assisted by the chief medical officer, who is in charge of clinical work. Members of the medical staff are on either United States Medical Corps or United States civil-service status, and are appointed to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 17 active and 2 dental corps members is organized on the closed plan, the chief medical officer acting as chief of staff. There is fairly extensive departmentalization with heads of departments and subdivisions who are active in control of the clinical work. The consulting staff of 20 members comprises an outstanding group of local medical and surgical specialists, who are selected and recommended for appointment by the chief medical officer. It was stated that some members of this group are active on the teaching faculty of Emory University School of Medicine. All of the consultants are on fee basis and are called as the need arises.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The program consists of consideration of clinical cases and deaths, surgical specimens and autopsy material, the discussion of medical papers and subjects, and sometimes administrative business. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologists and radiologists. Minutes and attendance records of the meetings are kept. Departmental meetings and/or clinicopathological conferences are not held.

There are no interns or residents on duty in the hospital at this time.

*Medical records.*—A full-time, trained librarian has charge of the completed medical records, assisted by an adequate corps of trained clerks. The records are prepared by the staff medical officers and appear to be complete in all details. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease and operation is up to date. The cross-indexes are used to some extent by the medical staff for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well-organized clinical and surgical pathological laboratories, in which all types of laboratory procedures are carried out. The part-time pathologist, Dr. Ricardo Mestre, is qualified by training and experience, and is a member of a national pathological society; he spends approximately half time in the department. He is assisted by four full-time, trained technicians, of whom one is registered. All tissues removed at operation are examined and full reports rendered.

The radiological department is well equipped with radiographic, fluoroscopic, superficial and deep therapy apparatus. One hundred milligrams of radium is available for use, this institution being one of the cancer centers of the Veterans' Administration. The pathologist, Dr. Ricardo Mestre, acts as roentgenologist and spends about half time in the department. He is qualified by training and experience, and is a member of the Georgia State Radiological Society. The full-time radiologist, Dr. H. S. Abrams, has excellent formal qualifications. Three full-time trained technicians are employed in the department.

The facilities for physical therapy in the hospital are fairly complete, and are supervised by a member of the department of medicine. Two full-time registered technicians are employed and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus and occupational therapy, all of which are completely supervised.

*Surgical department.*—The facilities for surgery consist of two major operating rooms in the main surgical suite, and a cystoscopic room in the radiological department, sterilizing and work rooms. The various rooms are situated to best advantage, and, while the facilities are sharply limited, are said to be adequate in extent for the present needs of the hospital. The supply of surgical

instruments seems to be sufficient in number and variety for any type of operation ordinarily performed in the hospital. Two graduate nurses and one orderly are assigned to the department.

The full-time surgical staff consists of five members, supervised by the chief of surgery. Much of the general and orthopedic surgery is done by members of the full-time staff without much specialization, but practically all major surgery in urology, tumor surgery, and ophthalmology is done by members of the consulting staff, and a consultant is frequently employed in orthopedic surgery. A small portion of the major ophthalmology surgery, and all surgery in otolaryngology is done by the staff specialist in ophthalmology-otolaryngology.

The chief of surgery is responsible, through the manager and chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed-staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by members of the medical and surgical staff, supervised by the chief of surgery, Lt. Col. John A. Thurston. Local, spinal, and pentothal sodium anesthetics are used; special records are made of anesthetics administered, but postanesthetic notations were not noted in examination of the medical records. Full recording of the physical examination, diagnostic laboratory procedures and the provisional diagnosis is required before the administration of an anesthetic may begin.

A record of infections occurring postoperatively in clean surgical cases is on file in the office of the chief of surgery. In the event that a postoperative infection occurs, the incident is carefully investigated, an attempt made to ascertain the source of infection and corrective measures are taken.

During the year 1943 there were 358 major and 449 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited amount of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery, but female patients are ordinarily not admitted. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. The allotment of beds for surgical patients is as follows: 55 for general surgery, urological surgery, orthopedics, and proctology; 9 for ophthalmology-otolaryngology; and 46 for tumor patients, half of the latter being for domiciliary patients. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 293, and 2,993 patients were admitted. A division of patients admitted into clinical services is not available due to the fact that admissions are through the reception out-patient department to the diagnostic service and cases are thoroughly worked up before the diagnosis is announced. The nearest possible approximation of surgical patients is said to be the number of operations performed, that is, 358 major and 449 minor.

In the out-patient department during 1943, for purely out-patient purposes, 1,784 patients were admitted for a total of 6,418 treatments, and 8,087 individuals were given 17,059 examinations, the latter probably for rating purposes.

*Obstetrics.*—This hospital does not maintain an obstetrical service.

*Out-patient department.*—A member of the full-time medical staff is in charge as chief of the out-patient and reception service, and four other members of the medical staff are on full-time assignment to the department. Patients are admitted in the usual out-patient sense for diagnosis and treatment in all usual departments, as well as for rating purposes, from 8:30 a. m. until 4 p. m., daily except Sunday. Complete records of patient visits, physical findings and treatments administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up on patients.



*Pharmacy.*—A full-time, registered pharmacist has supervision of the hospital pharmacy. Only pharmaceutical preparations of standard quality are used. Complete records of drug stock and prescriptions are maintained, and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 44 graduate nurses on duty at the time of survey, 12 of whom were in supervisory capacity and 32 on general duty, allowing a nurse-patient ratio of about 1 to 6½. Conferences of the entire nursing staff are held regularly every 2 weeks for the consideration of administrative and other matters. The nurses occupy a home which is of modern, fireproof construction.

There are, in addition to the graduate nurses, 52 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Two dietitians are employed in the organized dietary department of the hospital. Both dietitians are graduates of approved schools of dietetics and the chief of the department is a member of the American Dietetic Association. Members of this staff are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—Two full-time trained workers are employed in the department of medical social service. Social and financial investigations are made of patients when indicated, and full reports of these investigations are on file in the patients' medical records and in the department. Members of the department follow up discharged patients by means of home visits, mail and telephone.

*Library.*—The hospital has a medical library of 409 current, standard texts and receives 21 medical periodicals monthly. A full-time librarian is in charge of the medical library.

*Residencies.*—Plans have not been drawn up for graduate training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—This institution appears to have fairly good possibilities as a center for graduate training in general surgery inasmuch as the clinical material in admissions to the hospital seems to be sufficient for that purpose. The clinical material in admissions to the out-patient department is somewhat less than would be desired, and surgery appears to be definitely on the conservative side. It is problematical, therefore, whether or not the hospital could carry a resident through to completion of his training program, although it is probable that the resident would be given good, partial training. The chief medical officer and members of the surgical staff interviewed expressed interest in graduate training. All of these men appear capable and interested in their work.

Among the points of importance to be considered in connection with the possible establishment of graduate training programs in this hospital are: The need for departmental meetings and/or clinicopathological conferences as additional means for the review of the clinical work; full-time, qualified physicians in charge of the clinical laboratory and roentgenological department, and the percentage of autopsies performed. In the latter connection, it is recommended by the American College of Surgeons that, where graduate training programs have been established or are contemplated, the autopsy percentage be at least 50 percent and as much more as possible. The foregoing points are also of importance in the field of hospital standardization.

PAUL S. FERGUSON, M. D.,  
Director of Surveys.

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VETERANS' ADMINISTRATION HOSPITAL, HINES, ILL.

(Mr. Charles G. Beck, manager; Col. W. A. Colton (MC), chief medical officer)

JANUARY 20, 1945.

*General.*—This is a general hospital with an official bed capacity of 1,771. The physical plant consists of a four-story building of modern, fireproof construction. The equipment in all departments appears to be adequate for efficient diagnosis and treatment, and is of good quality. Construction is to begin soon on a cancer hospital of about 800 beds, which will function in conjunction with, and be located



immediately north of, this hospital. It is planned that, eventually, the permanent buildings of Vaughn General Hospital, of about 1,000-bed capacity, located immediately east of this institution, will become a part of the Veterans' Administration Facility.

The hospital is administered by a manager who is a layman, assisted by the chief medical officer and the clinical director. Members of the medical staff are on either United States Army Medical Corps or United States civil-service status and are assigned to this hospital by the medical director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 69 active and 6 dental corps members is organized on the closed plan, the chief medical officer acting as chief of staff. There is extensive departmentalization, with heads of departments and subdivisions who are active in control of the clinical work. The consulting staff of 17 members comprises an outstanding group of clinicians and teachers of the four medical schools in Chicago and represents all of the medical and surgical specialties. The consultants are on part-time salary basis, and visit the hospital regularly.

The medical staff meets each week throughout the year for a review of the clinical work of the hospital. The program consists of consideration of diagnoses and treatment, clinical cases in general, deaths, and occasionally administrative business matters. Departmental meetings in all departments and clinicopathological conferences are held weekly throughout the year. These meetings appear to afford an adequate review of the clinical work and are attended by representatives of the pathological and radiological departments. Minutes and attendance records of the general staff meetings are kept.

There are no interns or residents on duty in the hospital at this time.

*Medical records.*—The medical records are prepared by the staff officers and appear to be complete in essential details. A full-time librarian has charge of the completed records and is assisted by a large corps of trained clerks. Filing is by serial number, a recognized nomenclature is used, and cross-indexing according to disease is up to date. The cross-indexes, as far as developed, are used to some extent by the staff officers for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped clinical and surgical pathological laboratories in which all types of laboratory procedures are carried out. The full-time pathologist, Dr. W. L. McNamara, is well qualified, while his full-time assistant, Dr. R. J. Rogers, is qualified by training and experience. Thirteen full-time, trained technicians are employed, and two of them are registered with the national registry. All tissues removed at operation are examined and full reports rendered.

The radiological department is well equipped with radiographic, fluoroscopic, and superficial and deep therapeutic apparatus. A large quantity of radium is available for use. Dr. C. W. McClanahan is the full-time roentgenologist in charge of the department and he has a full-time assistant, Dr. J. T. Brackin. The full-time radiologist, Dr. Harry Slobodin, has two full-time assistants, Drs. G. A. Williams and G. A. Mednick. All members of the departmental staff are qualified by certification of the American Board of Radiology. A large group of trained, full-time technicians, of whom two are registered, is employed.

The facilities for physical therapy in the hospital are complete and are supervised by Dr. H. C. Mitchell, a member of the neurological staff. An adequate corps of trained, full-time technicians is employed and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery are of good quality although somewhat limited for a hospital of this size. There are five major operating rooms in the surgical suite, two cystoscopic rooms in the urological department, one major operating room in the department of ophthalmology-otolaryngology, and sterilizing and workrooms. The supply of surgical instruments is extensive in number and variety and is said by the staff surgeons to fulfill their needs. Eight graduate nurses, four student nurses, and seven orderlies are assigned to this department.

The full-time staff in general surgery and the surgical specialties consists of 16 members, supervised by the chief of department and heads of specialty divisions. There is specialization among members of the group for plastic, orthopedic, urological, and thoracic surgery, also in ophthalmology-otolaryngology; members of the general surgical group perform all operations in gynecology and

tumor surgery. One of the surgical consultants does all of the lobectomies and most of the thoracoplasties in thoracic surgery.

The chief of surgery is responsible, through the manager and the chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by members of the surgical staff, supervised by Dr. H. I. Lipson, a member of the general surgical group. The usual types of anesthesia are used, including cyclopropane and pentothal sodium; special records of anesthetics administered are not made. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

A record of infections occurring postoperatively in clean surgical cases is maintained in the office of the chief of surgery. The incident is carefully investigated whenever a postoperative infection occurs, the source of infection determined if possible and corrective measures taken.

During the year 1943 there were 1,968 major and 3,585 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general and specialized surgery were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all branches of medicine and surgery but only a moderate number of female patients are admitted despite the fact that certain classifications of them are eligible for treatment; hence, there is a marked shortage of clinical material in adult female diseases, as well as those among children. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. The number of beds for the various classes of surgical patients could not be ascertained, but 30 beds are set aside for medical and surgical conditions among women patients. Attention is called to the extensive facilities for the treatment of cancer, both in the hospital and in the reception out-patient department. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 1,534 and 10,194 patients were admitted. A division of patients admitted into clinical services is not available due to the fact that patients are admitted through the reception out-patient department to the diagnostic service and thoroughly worked up before the diagnosis is announced. The closest possible approximation of surgical patients among those admitted is said to be the number of surgical operations performed, which is given above.

In the out-patient department during 1943, for purely out-patient purposes, 14,788 patient visits were registered and 38,186 examinations were made.

Autopsies during 1943 were 400/1,126, or 36 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—This hospital does not maintain an obstetrical department.

*Out-patient department.*—The reception out-patient department is staffed by a chief of service and 11 assistants. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from about 8:30 a. m. until 4:30 p. m., daily except Sunday. Complete records of patient visits, physical findings and treatments administered, as well as the physical findings for rating purposes, are on file in the department. The appointment system is utilized as a means of follow-up on patients.

*Pharmacy.*—A full-time, registered pharmacist has supervision of the hospital pharmacy. All pharmaceutical preparations used are of standard quality. Complete records are maintained of drug stock and prescriptions, and narcotic supplies and records are checked regularly.

*Nursing.*—The nursing service is supervised by a full-time directress of nursing. There was a staff of 173 graduate nurses on duty at the time of survey,



24 of whom were in supervisory capacity and 149 on general duty, allowing a nurse-patient ratio of about 1 to 9. An accredited school of nursing for cadet nurses in the last 6 months of their training is conducted by the hospital, with faculty and all facilities for instruction, and 10 pupils were enrolled on the date of survey. Conferences of the entire nursing staff are held monthly for the consideration of administrative and other matters. The graduate and pupil nurses occupy homes which are of modern, fireproof construction.

There are, in addition to the graduate and pupil nurses, 277 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—The organized dietary department of the hospital employs 13 dietitians. All members of the group are graduates of approved schools and the chief and nine assistants are members of the American Dietetic Association. Student dietitians are received for instruction in the department. Members of this group are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchens, refrigerators, preparation and supply rooms were visited and found to be in sanitary condition.

*Medical social-service department.*—A full-time, trained directress has charge of the medical social-service department, and five qualified assistants are employed. Investigations of social conditions among patients are made when indicated and full reports of these investigations are on file in the patients' medical records and in the department. Discharged patients are followed up by means of home visits, mail and telephone.

*Library.*—A medical library of about 1,000 standard, current texts is maintained and 40 medical periodicals are received monthly. Heretofore, the hospital librarian has been in charge and the medical library has been open from 2:30 to 4:30 p. m. daily. It is anticipated that a full-time, qualified librarian will be placed in charge in the event that residents are assigned to the hospital and that the library will be open throughout the day.

*Residencies.*—A graduate training committee of the medical staff, consisting of the chief medical officer, the clinical director, the chief of surgery, the pathologist and chief of the radiological department has been appointed. A conference was held with the committee by representatives of the graduate training department of the college on October 16, 1944, at which time a specimen program of graduate training in general surgery was drawn up. Copies of the specimen program have been furnished to the Medical Director of the Veterans' Administration and to the authorities of this hospital, for consideration and adaptation to their needs. It is believed that this program, as outlined, may be applied, with certain modifications, to all of the 20 veterans' hospitals under survey. Thus far an affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The Veterans' Administration hospital at Hines offers excellent opportunities for graduate training in surgery and certain of the surgical specialties. The hospital is well organized for this purpose and the administration and medical staffs have a fine attitude toward an educational program in graduate training. There is an abundance of good teaching material in both in-patient and out-patient services and a large volume of surgery is done each year. An additional advantage to carrying out a teaching program is the very active and carefully selected consulting staff, consisting of the best teachers from the four medical schools in Chicago.

PAUL S. FERGUSON, M. D.,  
Director of Surveys.

#### VETERANS' ADMINISTRATION HOSPITAL, INDIANAPOLIS, IND.

(Lt. Col. Earl H. Hare, chief medical officer; B. C. Moore, manager)

JANUARY 27, 1945.

*General.*—This is a general hospital with an official bed capacity of 345. The physical plant consists of two buildings, of three to five stories, modern, fireproof construction. The equipment in all departments appears to be adequate for good diagnosis and care of patients, and is of good quality.

The hospital is administered by a manager who is a layman, assisted by the chief medical officer and a clinical director. Members of the medical staff are on United States civil-service status and are assigned to this hospital by the



medical director of the Veterans' Administration. The staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 14 active members is organized on the closed plan, the chief medical officer acting as chief of staff, assisted by the clinical director. There is basic departmentalization, with departmental heads who are active in control of the clinical work. The consulting staff of 10 members comprises an outstanding group of local medical and surgical specialists, some of whom are said to be on the faculty of the Medical School of the University of Indiana. Consultants are on fee basis and are called to the hospital as the need arises.

It was stated that the medical staff meets regularly throughout the year for a review of the clinical work of the hospital, but only 40 weekly meetings had been held in the 12 months preceding the date of survey. According to the minutes recorded, the program for many of the meetings was composed entirely of administrative-business discussions, but there has been at least one meeting monthly in which there was discussion of clinical cases in general, deaths, questions of diagnosis and treatment. The general nature of the programs left the impression that an attempt was being made to carry out the letter, rather than the spirit, of hospital standardization, inasmuch as the clinical work of an institution of this size cannot be adequately reviewed short of weekly meetings devoted entirely to the clinical review. Departmental meetings and clinicopathological conferences are not held.

There are no interns or residents on duty in the hospital.

*Medical records.*—The medical records are prepared by the staff medical officers and appear to be complete in all essential details. A full-time, trained librarian has charge of the completed records, assisted by a large corps of trained clerks. Filing is by serial number, a recognized nomenclature is used, and cross-indexing according to disease is up to date. The cross-indexes are used to some extent by the members of the medical staff for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well-organized clinical and surgical pathological laboratories, in which all types of laboratory procedures are carried out. The space allotted to the department appears to be small and cramped, but is said by the pathologist to be sufficiently large to carry on efficient work. The part-time pathologist, Dr. A. J. Bown, is qualified by training and experience and spends about half-time in the department. He is assisted by three full-time, trained technicians, two of whom are registered. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The pathologist, Dr. A. J. Brown, also acts as roentgenologist and spends about half-time in the department. His qualifications as roentgenologist consists of training and experience. One full-time, trained technician is employed in the department. The department is an extremely active one and the volume of work done is far too great for one technician to care for promptly and efficiently; hence, sufficient technical help should be employed to render prompt and efficient service to patients and members of the medical staff.

Complete physiotherapy facilities are provided in the hospital and are supervised by Dr. D. R. Adams, the full-time physiotherapy officer. Two full-time registered technicians are employed and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of one major room and a fracture room in the main surgical suite, a cystoscopic room in the roentgenological department, sterilizing and work rooms. While these facilities would appear to be very limited, they are conveniently situated and are said by the surgeons to be adequate in extent for the present needs of the hospital. The supply of surgical instruments is extensive and seems to be sufficient for any type of operation ordinarily performed by the surgical staff. Two graduate nurses and one orderly are assigned to the department.

The full-time surgical staff consists of four members, supervised by the chief of department. The chief of the service and one assistant do all of the general surgery, including orthopedics and gynecology, one member performs all operations in urological surgery, and the fourth member is the specialist in ophthalmology-otolaryngology with responsibility for all surgery in that combined spe-

cialty. It appears that the services of the surgical consultant are seldom employed as far as the performance of operations is concerned.

The chief of surgery is responsible, through the manager, chief medical officer and clinical director, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed-staff organization, and complete preoperative recording.

Anesthetics in the department are administered by members of the surgical and medical staffs and are supervised by Dr. V. F. Tremor, chief of surgery. The usual types of anesthesia are used, including pentothal sodium: Special records are not made of the anesthetics administered. Full recording of the physical examination, diagnostic laboratory procedures and the provisional diagnosis is required before the administration of an anesthetic may begin.

Any infections occurring postoperatively in clean surgical cases are recorded in the office of the chief of surgery. In the event that a postoperative infection occurs, the incident is carefully investigated, the source of infection determined if possible, and corrective measures taken.

During the year 1943 there were 500 major and 682 minor operations performed in the hospital, including those in ophthalmology, otolaryngology. It was stated that all surgical material, with the possible exception of ophthalmology-otolaryngology, would be available for use in the training of residents. Records as to the nature of the operations performed, collectively, or their division into general and specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeon will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery, but the admission of female patients is sharply limited at present. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. There is no specific number of beds allotted to the care of surgical patients. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 210, and 2,430 patients were admitted. A division of the admissions into clinical services is not available due to the fact that patients are admitted through the reception out-patient department to the diagnostic service and thoroughly worked up before the diagnosis is announced. The closest possible approximation of surgical patients among those admitted is said to be the number of surgical operations performed, which is 500 major and 682 minor.

In the out-patient department during 1943, for purely out-patient purposes, 1,648 individuals were given 2,387 treatments and 3,538 patients were admitted for a total of 8,152 examinations, the latter probably chiefly for rating purposes.

Autopsies during 1943 were 39/192, or 20 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—The hospital does not maintain an obstetrical service.

*Out-patient department.*—The clinical director of the hospital is in charge of the out-patient reception service, assisted by other members of the full-time medical staff. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from about 8 a. m. until 4:30 p. m., daily except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up of patients.

*Pharmacy.*—A full-time registered pharmacist has supervision of the hospital pharmacy. All pharmaceutical preparations used are of standard quality. Complete records of prescriptions and drug stock are maintained, and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 33 graduate nurses on duty at the time of surgery, 6 of whom were in supervisory capacity and 27 on general duty, allowing a nurse-patient



ratio of about 1 to 6½. Conferences of the entire nursing staff are held regularly each week throughout the year, for the consideration of administration and other matters. The nurses occupy a home which is of modern, fireproof construction.

There are, in addition to the graduate nurses, 39 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Two dietitians are employed in the organized dietary department of the hospital, both of whom are graduates of approved schools of dietetics and members of the American Dietetic Association. Members of the department are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—The department of medical social service employs one full-time trained worker, who makes investigations of home conditions when indicated. Full reports of these investigations are on file in the patients' medical records and in the department. The department follows up discharged patients to some extent through the media of mail and telephone.

*Library.*—The medical library consists of 269 current standard textbooks and 16 medical periodicals are received monthly. A full-time librarian has charge of the medical library.

*Residents.*—Plans have not been drawn up for graduate training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The possibilities of the Veterans' Administration hospital in Indianapolis as a center for graduate training in general surgery appear to be rather limited. The quantity of clinical material in admissions to the hospital justified the establishment of a program, but the material in admissions to the out-patient department is limited and the treatment of patients by surgery seems to be definitely on the conservative side. The medical staff appears to be well organized, but fellowship in the college is not represented among members of the surgical group. It is my opinion that this institution is not qualified to take on a resident for training in a 4-year program; however, it should be considered in the over-all program in veterans' hospitals as eligible to give partial training. There is every probability that a resident would receive good training during 1 or 2 years of residency.

Among the points to be considered if a graduate training program is to be established in this institution are: The adequate review of the clinical work of the hospital in general staff meetings and the holding of departmental meetings and/or clinicopathological conferences; cross-indexing of the medical records according to operation; full-time, qualified physician specialists in charge of the clinical laboratory and roentgenological department; a sufficient number of trained technicians in the roentgenological department to render prompt and efficient service; the possibility of additional space being needed by the clinical laboratory and in the surgical facilities; and the percentage of autopsies. It is recommended by the American College of Surgeons that the autopsy percentage in hospitals where graduate training programs are functioning or are contemplated should be at least 50 percent and as much more as possible. All of the foregoing considerations are likewise of importance in the field of hospital standardization.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*

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VETERANS' ADMINISTRATION HOSPITAL, WADSWORTH, KANS.

(Col. Charles M. Pearsall, manager; Dr. Gail D. Allee, chief medical officer)

MARCH 21, 1945.

*General.*—This is a general hospital with an official bed capacity of 742. The physical plant at the time of survey consisted of four hospital buildings of four to six stories and basement, modern, fireproof construction. The buildings located on the home-hospital grounds, formerly used for domiciliary purposes, have been vacated and some of them are being renovated and remodeled for hospital purposes; in addition, several new brick, fireproof buildings are being built, making a total of 14 buildings, renovated and new, with a bed capacity of 1,130.



These beds, and 120 beds in the general-hospital portion of the institution, are to be occupied by neuropsychiatric patients. It is expected that 400 beds in the new construction will be ready for occupancy within 60 days from the day of survey. The equipment in all departments appears to be adequate and is of good quality.

The hospital is administered by a manager, who is a layman, and is assisted on the clinical side by a chief medical officer and clinical director. Members of the medical staff are on either United States Army Medical Corps or United States civil-service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 29 active members is organized on the closed plan, the chief medical officer acting as chief of staff. There is basic departmentalization with departmental heads who are active in the control of the clinical work. The consulting staff of three members includes a general surgeon, a specialist in ophthalmology-otolaryngology, and a roentgenologist, all from nearby cities and all of whom are on fee basis.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The program consists of the consideration of clinical cases and deaths, tissue specimens and autopsy materials, discussion of medical subjects related to the care and treatment of patients, and sometimes administrative matters or medical motion pictures in addition. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist-radiologist. Minutes and attendance records for the general-staff meetings are kept. Departmental meetings or clinicopathological conferences are not held.

There are, at present, no interns or residents in the hospital.

*Medical records.*—The medical records are prepared by the staff medical officers and appear to be complete in all details. A full-time, trained librarian has charge of the completed records, assisted by a large corps of trained clerks. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease is up to date. The cross-indexes, as far as developed, are used but little by the medical staff for group studies or other purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped clinical and surgical pathological laboratories in which all of the usual types of laboratory procedures are carried out; some of the more unusual serological tests, however, are sent to the veterans' hospital at Hines, Ill. The part-time pathologist, Maj. S. F. Hoge, is qualified by training and experience and spends approximately half time in the department. He is assisted by four full-time, trained technicians, two of whom are registered. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The pathologist, Maj. S. F. Hoge, also acts as roentgenologist and spends about half of his time in this department. He is qualified for roentgenology by training and experience. One full-time, trained technician is employed in the department.

The facilities for physical therapy are complete and are supervised by Capt. M. Hoberman, orthopedist on the surgical staff. Two full-time, trained technicians are employed and complete records of treatment are maintained in the department. Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major operating rooms, plaster rooms, cystoscopic room in the roentgenological department, one major operating room for ophthalmology-otolaryngology, sterilizing and work rooms. The various rooms are situated for the greatest convenience and appear to afford adequate surgical facilities for the present size of the hospital. The supply of surgical instruments is extensive and probably is sufficient for any operation the surgeons may be called upon to perform. One graduate nurse is regularly assigned to the department and additional nurses are available when surgery is to be done.

The full-time general surgical staff consists of four members, supervised by the chief of surgery. The general, orthopedic, urological, and neurosurgery is done by members of the full-time staff without much specialization. The one ophthalmologist-otolaryngologist on the surgical staff does all of the surgery in that combined specialty.

The chief of surgery and the ophthalmologist-otolaryngologist are responsible, through the manager and the chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the surgical staff necessarily share in their responsibility, however. Other means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

All anesthetics in the department are administered by members of the surgical staff and are supervised by Maj. J. B. Griffin, a staff surgeon. The usual types of anesthesia are used, including pentothal sodium; special records are made of anesthetics administered and there are some postanesthetic notations recorded. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

Infections occurring postoperatively in clean surgical cases are recorded in patients' medical records, whereas there should be a complete, centralized record of these infections in the office of the chief of surgery or elsewhere in the hospital.

During the year 1944 there were 240 major and 296 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general or specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be done by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeon will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery, and female patients are admitted only for emergency conditions. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. While there are no beds allotted to the various types of surgical patients, at present, 200 beds are reserved for all surgical patients. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1944 the average daily census of the hospital was 480, and 3,536 patients were admitted. A division of patients admitted into clinical services shows that the following were admitted for surgical treatment: 536 in general surgery, 8 in plastic surgery, 138 in proctology, 8 in thoracic surgery, 11 in neurological surgery, 82 in orthopedic surgery, 41 in urological surgery, 15 in ophthalmology, 21 in otolaryngology; in addition, 241 acute fractures were admitted for treatment and 11 open reductions were performed among them.

In the out-patient department during 1944 there were 27,319 patient visits, of which 3,178 visits were in general surgery and the allied surgical specialties.

Autopsies during 1944 were 64/251, or 26 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—An obstetrical service is not maintained in the hospital.

*Out-patient department.*—The reception out-patient department is staffed by a chief of service and four assistants, all members of the full-time medical staff. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8:30 a. m. until 4:30 p. m., daily except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and are on file in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—The hospital pharmacy is supervised by a full-time, registered pharmacist. Only pharmaceutical preparations of standard quality are used. Complete records of drug stock and prescriptions are maintained, and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 68 graduate nurses on duty at the time of survey, 8 of whom were in supervisory capacity, and 60 on general duty, allowing a nurse-patient ratio of about 1 to 7. Conferences of the entire nursing staff are held monthly for the consideration of administrative and other matters. The nurses are housed in a home that is of modern, fireproof construction.



There are, in addition to the graduate nurses, 79 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Three dietitians are employed in the organized dietary department of the hospital. All are graduates of approved schools of dietetics and all are members of the American Dietetic Association. Members of the departmental staff are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchens, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—One full-time, trained investigator is employed in the department of medical social service. Her work is confined to medical social-service investigations among the syphilitic patients, and full reports of these investigations are on file in the patients' medical records and in the department. The department follows up discharges through the health department of the State of Kansas, which sends reports to the health departments of other States if indicated.

*Library.*—The medical library in the hospital consists of 398 current, standard texts and 29 medical periodicals are received monthly. A full-time librarian is in charge of the medical library.

*Residencies.*—Plans have not been drawn up for graduate training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The Veterans' Administration hospital in Wadsworth appears to be sufficiently well organized as to administration and surgical staff to warrant consideration of the establishment of a graduate training program in general surgery. The volume of clinical material in admissions to the hospital and the out-patient department is probably sufficient for adequate training but the treatment of patients by surgery appears to be on the conservative side and the volume of surgery done is somewhat less than would be required for a fully developed program. It is my opinion that, at present, this hospital is eligible to take part in the over-all graduate training program but can scarcely undertake complete training of surgeons. Members of the surgical and diagnostic staff appear to be interested in their work but expressed only mild interest in the possibility of graduate training in surgery coming to their hospital. The chief of surgery is a fellow of the American College of Surgeons.

The points of importance to be considered in connection with the establishment of a program of graduate training in surgery in this hospital are: Surgical department meetings and clinicopathological conferences at regular and frequent intervals; cross-indexing of the medical records according to operation; qualified full-time physicians in charge of the clinical laboratory and X-ray departments; a substantial increase in the autopsy percentage, inasmuch as an autopsy percentage as near to 50 percent as possible is recommended by the American College of Surgeons for hospitals where graduate training programs are being conducted or are contemplated; complete, centralized recording of infection occurring postoperatively in clean surgical cases.

The foregoing points are also of importance in the field of hospital standardization.

PAUL S. FERGUSON, M. D.,  
Director of Surveys.

#### VETERANS' ADMINISTRATION HOSPITAL, MINNEAPOLIS, MINN.

(Maj. Harry E. Bank, chief medical officer; Mr. C. D. Hibbard, manager)

MARCH 22, 1945.

*General.*—This is a general hospital with an official bed capacity of 786. The physical plant consists of five buildings of two to five stories, modern, fireproof construction. Equipment in all departments appears to be adequate and is of good quality.

The hospital is administered by a manager who is a layman, assisted by the chief medical officer and the clinical director. Members of the medical staff are on either United States Army Medical Corps or United States Civil Service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.



*Medical staff.*—The full-time medical staff of 53 active and 4 Dental Corps members is organized on the closed plan, the chief medical officer acting as chief of staff. There is basic departmentalization, with heads of departments who are active in control of the clinical work. The consulting staff of four members includes local surgical specialists and an anesthetist of outstanding ability. Some members of this group are on the faculty of the medical school of the University of Minnesota, and all are part-time, salary basis and visit the hospital regularly.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The programs consist of consideration of clinical cases and deaths, pathological tissues and autopsy material, discussion of medical subjects of importance in the care and treatment of patients, sometimes administrative business and occasionally medical motion pictures. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist and radiologist. Minutes and attendance records of the meetings are kept. Departmental meetings and clinicopathological conferences are not held.

There are at present no residents or internes in the hospital.

*Medical records.*—A full-time, trained librarian has charge of the completed medical records, assisted by a large corps of trained clerks. The records are prepared by the staff medical officers and appear to be complete in all details. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease is up to date. The cross-indexes, as far as developed, are said to be used but little by the medical staff for group studies or other purposes.

*Diagnostic and adjunct facilities.*—The clinical and surgical pathological laboratories of the hospital are fully equipped and well organized, and all types of laboratory procedures are carried out. The full-time pathologist, Maj. William Hentel, is qualified by training and experience. He is assisted by a corps of seven full-time, registered technicians. All tissues removed at operation are examined and full reports rendered. This department appears to be in need of additional space, inasmuch as the equipment is crowded in the present space, which delays the carrying out of procedures and may, to some extent, affect the accuracy of the technicians' work.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The full-time roentgenologist, Capt. H. A. Myers, is qualified by training and experience. Four full-time trained technicians are employed in the department, two of them registered.

Facilities in the physical therapy department of the hospital are complete and are supervised by Dr. L. C. Jensen, a member of the orthopedic surgical staff. Five full-time, trained technicians are employed and two of them are registered. Complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major operating rooms, a cystoscopic room in the urological department, one minor room for ophthalmology-otolaryngology, sterilizing and work rooms. The supply of surgical instruments seems to be sufficient in extent and variety for any type of operation usually performed in the hospital. Five graduate nurses and one orderly are assigned to the department.

The present facilities for surgery are entirely inadequate as regards operating space and safeguarding against cross infection. The two major operating rooms are both very small; there is not a sufficient number of scrub-up sinks; the surgeons' dressing room is not more than 8 by 8 feet in size and the nurses' work-room and the anesthetic storage room are much too small for the purpose intended. The doorways leading into the operating rooms, the surgeons' dressing room, and the scrub-up space, from the corridor of the surgical suite, are not closed by doors or by any other means. As a result there is no privacy in operating or dressing rooms, offering the temptation to the surgeons to scrub inadequately, and making no provision for the prevention of cross infection. Larger, more extensive and more suitably appointed facilities for surgery should be provided.

The full-time, general surgical staff consists of six members, supervised by the chief of surgery. Most of the general and orthopedic surgery is done by members of the full-time staff, without much specialization, while the urological surgery is done by the full-time, urological surgeon. A fair portion of the gen-

eral and orthopedic surgery, and all of the thoracic surgery, is done by members of the consulting surgical staff. There is one ophthalmologist-otolaryngologist on the staff who does all of the surgery in that combined specialty.

The chief of surgery and the ophthalmologist-otolaryngologist are responsible, through the manager and the chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in their responsibility, however. Additional means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by members of the surgical staff and are supervised by Lt. Michael Petras. The usual types of anesthesia are used, including cyclopropane, ethylene, and pentothal sodium; special records are made of anesthetics administered and there are some post-anesthetic notations recorded. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

A record is not kept of infections occurring postoperatively in clean surgical cases in the hospital. A definite plan should be formulated and adopted whereby a complete record would be kept of all postoperative infections, an attempt would be made to ascertain the source of infection, following which positive corrective measures should be taken. The record of infections, investigation of them, and the corrective measures taken should be maintained in the office of the chief of surgery or other convenient place in the hospital.

Operations performed in the hospital during the year 1944 numbered 450 major and 3,356 minor. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have performed a limited number of major and minor operations under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male and female veteran patients are admitted in all general branches of medicine and surgery. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. Beds for surgical patients are allotted as follows: 81 for general surgery and ophthalmology-otolaryngology, 89 for orthopedic surgery, and 78 for urological surgery. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

The average daily census of the hospital during 1944 was 618, and 3,789 patients were admitted. An approximate division into clinical services of the patients admitted indicates that the following were admitted for surgical treatment: 746 in general surgery, 7 in plastic surgery, 115 in proctology, 49 in thoracic surgery, 139 in orthopedic surgery, 48 in urological surgery, 4 in gynecological surgery, 37 in ophthalmology, and 138 in otolaryngology; in addition, 72 acute fractures were admitted and 10 open reductions were performed among them.

In the out-patient department during 1944, for purely out-patient purposes, there were 11,556 patient visits. An approximate division of the visits into general surgery and the surgical specialties was not available.

Autopsies during 1944 were 122/289 or 42 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—The hospital does not maintain an obstetrical service.

*Out-patient department.*—The out-patient department is staffed by a chief of service and several assistants. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8 a. m. until 4:30 p. m. daily except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—A full-time, registered pharmacist has supervision of the hospital pharmacy. All pharmaceutical preparations used are of standard quality. Com-



plete records of drug stock and prescriptions are maintained and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 85 graduate nurses on duty at the time of survey, 13 of whom were in supervisory capacity and 72 on general duty, allowing a nurse-patient ratio of about 1 to 7. Conferences of the entire nursing staff are held regularly each month for the consideration of administrative and other matters. The nurses are housed in a home that is of modern, fireproof construction.

There are, in addition to the graduate nurses, 101 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Five dietitians are employed in the organized dietary department of the hospital. All of the dietitians are graduates of approved schools and the chief and two of her assistants are members of the American Dietetic Association. Members of the departmental staff are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical social-service department.*—Four full-time workers are employed in the department of medical social service, three of whom are said to be qualified by formal training. Social and financial investigations are made of patients when indicated, and full reports of these investigations are on file in the patients' medical records in the department. The follow-up of discharged patients is chiefly through visits to their homes, allowing first-hand investigation.

*Library.*—The hospital maintains a medical library of about 200 current, standard texts and receives 28 medical periodicals monthly. A full-time librarian is in charge of the medical library.

*Residencies.*—A committee of the medical staff, of which the chief medical officer is chairman, has been appointed for graduate training purposes, but it was stated that nothing has been done toward drawing up programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—This institution would appear to be eligible for inclusion among those in which the establishment of a graduate training program in general surgery may be considered, inasmuch as the surgical staff is well organized and administered, the volume of clinical material in admissions to the hospital and outpatient department, and the volume of surgery, are sufficient for the purpose. It is probable that a full 4-year program could be carried out, and especially so when the facilities of the University of Minnesota Medical School are available to supplement the instruction given by the surgical staff of the hospital. Dr. O. H. Wangenstein, professor of surgery, and Dr. E. T. Bell, professor of pathology of the medical school, were interviewed during the visit and they were positive in their opinion that the authorities of the medical school would cooperate fully in a graduate training program in this hospital. The chief of surgery is a fellow of the American College of Surgeons. He and several of his assistants were interviewed and all appear to be high-class men. All were extremely interested in the possibility of a graduate training program being established in the hospital.

Points of importance to be considered in connection with the establishment of a graduate training program in this institution are: surgical departmental meetings and/or clinicopathological conferences at frequent and regular intervals; cross-indexing of the medical records according to operation; additional space for the clinical laboratory, if such is found to be necessary; surgical operative facilities sufficient in extent and quality to insure that first-class surgery may be done and first-class results obtained; complete recording, investigation, and elimination insofar as possible of infections occurring postoperatively in clean surgical cases; full-time, qualified physicians in charge of the clinical laboratory and roentgenological departments. The foregoing are also of importance in the field of hospital standardization and should have full consideration in that department.

PAUL S. FERGUSON, M. D.,  
Director of Surveys.



## VETERANS' ADMINISTRATION HOSPITAL, JEFFERSON BARRACKS, MO.

(Maj. Ernest V. Edwards, clinical director; Dr. Walter A. German, manager)

MARCH 8, 1944.

*General.*—This is a general hospital with an official bed capacity of 597. The physical plant consists of three hospital buildings, of two to three stories and basement, modern, fireproof construction. The equipment in all departments appears to be entirely adequate for efficient diagnosis and treatment, and is of good quality.

The hospital is administered by a manager who is a layman, assisted by the chief medical officer. Members of the medical staff are on United States civil-service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 20 active and 2 Dental Corps members is organized on the closed plan; the chief medical officer acts as chief of staff. There is basic departmentalization with department heads who are active in the control of the clinical work. There is a consulting staff of seven members, comprising an outstanding group of clinicians and teachers of the two medical schools in St. Louis, and representing several of the medical and surgical specialties. Members of the latter group are on fee basis, and are called to the hospital as the need arises.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The program consists of clinical cases in general, diagnoses and treatment, deaths and autopsy material, administrative matters, and there are occasional symposia or group studies. Departmental meetings in medicine and surgery are held at irregular intervals. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist-radiologist. Minutes and attendance records of the general staff meetings are kept. Clinicopathological conferences are not held.

There are no interns or residents on duty in the hospital at this time.

*Medical records.*—A full-time, trained librarian has charge of the completed medical records, assisted by a large corps of trained clerks. The records are prepared by the staff medical officers and appear to be complete in all essential details. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease and operation is up to date. The cross-indexes are used to some extent by the medical staff for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well-organized clinical and surgical pathological laboratories, in which all types of laboratory procedures are carried out. The part-time pathologist, Dr. D. E. Faxon, is qualified by training and experience, and spends approximately half-time in the department. He is assisted by five full-time, trained technicians, of whom two are registered. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The pathologist, Dr. D. E. Faxon, also acts as roentgenologist and spends about half-time in this department. He is qualified for the position of roentgenologist by training and experience. One full-time, trained technician is employed. It was stated by the chief medical officer and the roentgenologist that there has been a recent great increase in the volume of work in this department, much more than can be efficiently handled by one technician. They stated that their requests for additional technical help have been without result. A sufficient number of technicians to render prompt and efficient service to members of the medical staff and patients should be supplied.

The facilities for physiotherapy in the hospital are complete, and are supervised by Dr. J. J. Szazama, a member of the staff of the department of medicine. Three full-time, trained technicians are employed, of whom one is registered, and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major and one minor operating room, a cystoscopic room in the roentgenological department, sterilizing and workrooms. The various rooms are situated to best advantage and are said by the chief of surgery to be adequate in extent for the present needs of the hospital. The supply of surgical instruments appears to be sufficient

in number and variety for any type of operation the surgeons may be called upon to perform. Two graduate nurses and two orderlies are assigned to the department.

The full-time surgical staff consists of five members, three in general surgery and a specialist each in urology and ophthalmology-otolaryngology, all supervised by the chief of surgery. All of the general surgery, including orthopedics, is done by the three general surgeons without specialization, while the operations in urology and ophthalmology-otolaryngology are performed by the specialists in each of those divisions. It appears that the services of the surgical consultant are not utilized as far as the actual performance of operations is concerned.

The chief of surgery is responsible, through the manager and the chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered by members of the surgical staff, supervised by the chief of surgery, Dr. G. E. Riggs. The usual types of anesthesia are used, including pentothal sodium; nitrous oxide is not employed, however. Special records of anesthetics are not made. Full recording of the physical examination, diagnostic laboratory procedures and the provisional diagnosis is required before the administration of an anesthetic may begin.

Any infections occurring postoperatively in clean surgical cases are recorded in the office of the chief of surgery. In the event that a postoperative infection occurs, the circumstances are investigated, an attempt made to trace the infection to its source, and corrective measures taken.

During the year 1943 there were 688 major and 557 minor operations performed in the hospital. Thirty-two acute fractures were admitted for treatment, and 12 open reductions were performed with two postoperative infections among them. Records as to the nature of the total operations performed, collectively, or their division into general and specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all branches of medicine and surgery, but the admission of female veteran personnel is sharply limited. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. There are no beds allotted for the various types of surgical patients except that six beds are set aside for female patients with surgical and medical conditions. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 474, and 3,637 patients were admitted. A division of patients admitted into clinical services is not available due to the fact that admissions are through the reception out-patient service to the diagnostic service and each case is thoroughly worked up before the diagnosis is announced. The nearest possible approximation of the number of surgical patients admitted is said to be the number of operations performed, which is 688 major and 957 minor.

In the out-patient department during 1943, for purely out-patient purposes, 2,496 patients were given a total of 6,194 treatments, and 6,176 patients were admitted for a total of 17,166 examinations, the latter probably, chiefly, for rating purposes.

Autopsies during 1943 were 54/295 or 18 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—This hospital does not maintain an obstetrical service.

*Out-patient department.*—The out-patient reception department is staffed by a chief of service and five assistants. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from about 8 a. m. until 4:30 p. m., daily except Sunday. Complete records of patient visits, physical findings and treatment administered, as well as the physical findings for



rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—A full-time, registered pharmacist has charge of the hospital pharmacy. All pharmaceutical preparations used are of standard quality. Complete records are maintained of drug stocks and prescriptions, and narcotic supplies and records are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 36 graduate nurses on duty at the time of survey, 19 of whom were in supervisory capacity and 17 on general duty, allowing a nurse-patient ratio of about 1 to 13. Conferences of the entire nursing staff are held each week throughout the year for the consideration of administrative and other matters. The nurses occupy a home that is of modern, fireproof construction.

There are, in addition to the graduate nurses, 94 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Three dietitians are employed in the organized dietary department of the hospital. All of the dietitians are graduates of approved schools, and the chief and one assistant are members of the American Dietetic Association. Members of the department are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, and preparation and supply rooms were visited and found to be in sanitary condition.

*Medical social-service department.*—Two full-time, trained workers are employed in the department of medical social service. Social and financial investigations of patients are made when indicated, and full reports of these investigations are on file in the patients' medical records and in the department. Discharged patients are followed up by the investigators through the media of home visits, mail, and telephone.

*Library.*—The medical library of the hospital consists of 35 standard, current texts, and 21 current periodicals are received monthly. A full-time librarian is in charge of the medical library.

*Residencies.*—Plans have not been drawn up for graduate training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—This institution appears to present fair possibilities as a center for graduate training in general surgery, inasmuch as the clinical material in admissions to the hospital and the out-patient department, and the volume of surgery done should afford good training for a surgical resident. It is problematical, however, whether or not the hospital could carry a surgical resident through a full 4-year program and at the same time give him adequate training. It is my opinion that the institution should be considered as eligible to give partial training if a 4-year program is not decided upon. Members of the surgical staff interviewed appeared to be high-class men and interested in their work, but they expressed only mild interest in the subject of graduate training in surgery. One member of the surgical staff, a general surgeon, is a fellow of the American College of Surgeons.

Among the points of importance to be considered in connection with the possible establishment of a graduate-training program in this hospital are: Departmental meetings and clinicopathological conferences of the medical staff at regular and frequent intervals, to insure adequate review of the clinical work; full-time, qualified physician specialists in charge of the clinical laboratory and roentgenological department; and the autopsy percentage. It is recommended by the American College of Surgeons that, in hospitals where graduate training programs are functioning or are contemplated, the autopsy record be as near 50 percent as possible and even higher if feasible. Of importance in the field of hospital standardization, in addition to the above, are, the fact that special records are not made of anesthetics and the comparatively high ratio of graduate nurses to patients.

PAUL S. FERGUSON, M. D.

*Director of Surveys.*



## VETERANS' ADMINISTRATION HOSPITAL, BATH, N. Y.

(Col. John A. Hadley, manager; Dr. Roy W. Woodward, clinical director)

AUGUST 11, 1944.

*General.*—This is a general hospital with an official bed capacity of 428. The physical plant consists of a five- to six-story, modern, fireproof building. The equipment in all departments appears to be adequate for efficient diagnosis and treatment, and is of good quality.

The hospital is administered by a manager who is a layman, assisted by the clinical director. Members of the medical staff are on either United States Civil Service or United States Army Medical Corps status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 14 active and several Dental Corps members is organized on the closed plan, the chief medical officer acting as chief of staff. There is basic departmentalization with department heads who are active in control of the clinical work. A consulting staff of three members is made up of local specialists in medicine and surgery. Two members of this group, a general surgeon and an internist, are on part-time salary basis and visit the hospital regularly, while the third member, an orthopedist, is on fee basis and is called as the need arises.

The medical staff meets each week throughout the year for a review of the clinical work of the hospital. The program consists of consideration of clinical cases and deaths in general, and autopsy material. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist-radiologist. Minutes and attendance records of the general staff meetings are kept. Departmental meetings and clinicopathological conferences are not held.

There are no interns or residents in the hospital at present.

*Medical records.*—The medical records are prepared by the staff officers and appear to be complete in all essential details. A full-time, trained librarian has charge of the completed records, assisted by a moderate-sized corps of trained clerks. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease is up to date. The cross-indexes, as far as developed, are used to some extent by the medical staff for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well-organized clinical and surgical pathological laboratories in which the ordinary types of laboratory procedures are carried out; some pathological tissues are sent to the Bronx Hospital of the Veterans' Administration for diagnosis, however. The part-time pathologist, Maj. R. E. Alexander, qualified by training and experience, spends about half-time in this department. He is assisted by three full-time, trained technicians. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is equipped with radiographic and fluoroscopic apparatus and the diagnostic unit is calibrated for superficial therapy. The pathologist, Major Alexander, also acts as roentgenologist and is a Diplomate of the American Board of Radiology in radiology. He spends about half-time in this work and is assisted by two full-time, trained technicians, of whom one is registered.

The facilities for physical therapy in the hospital are fairly complete and are supervised by the pathologist-radiologist. Two full-time, trained technicians are employed and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major and one minor operating rooms, a cystoscopic room, sterilizing and work rooms. The various rooms are situated to good advantage and are considered by the surgeons to be adequate in extent for the present needs of the hospital. The supply of surgical instruments is extensive in number and variety and is probably sufficient for any type of operation ordinarily performed. Two graduate nurses and one orderly are assigned to the department.

The full-time surgical staff consists of the chief of service, one assisting general surgeon, and the ophthalmologist-otolaryngologist. The surgical consultant performs probably 5 percent of the operations in general surgery and the consultant in orthopedics is employed only occasionally. The remaining general and allied specialized surgery is done by the two full-time general staff surgeons. All surgery in ophthalmology-otolaryngology is done by the one staff member assigned to that combined specialty.

The chief of surgery is responsible, through the manager and chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and speciality divisions necessarily share in his responsibility, however. Additional means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by medical anesthetists and are supervised by Lt. Col. S. P. Funkhouser, chief of surgery. All usual types of anesthesia are used, including pentothal sodium; special records are not made of anesthetics administered. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis are required before the administration of an anesthetic may begin.

A record is maintained in the office of the chief of surgery of any infections occurring postoperatively in clean surgical cases. The circumstances of the case are carefully investigated when such an infection occurs, the source of infection determined if possible, and appropriate corrective measures taken.

During the year 1943 there were 157 major and 232 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeon will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery, while, at present, female patients are admitted chiefly for gynecological conditions. It should be noted that residents in the nearby domiciliary home of 1,477 beds are hospitalized in this institution. Ample provision is made for the care of patients with communicable diseases as well as for segregation and isolation. The beds assigned for the care of surgical patients of all types number 128. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 312 and 2,614 patients were admitted. A division of patients admitted into clinical services are not available due to the fact that admissions are through the reception out-patient department to the diagnostic service and cases are thoroughly worked up before the diagnosis is announced. The nearest possible approximation of surgical patients among the admissions is said to be the number of operations performed, which is 157 major and 232 minor. During the year 53 acute fractures were admitted for treatment and 6 open reductions were performed among them, with no postoperative infections.

In the out-patient department during 1943, 9,722 patients were given 45,159 treatments, and 6,675 individuals were subjected to 15,756 examinations, many of the latter probably for rating purposes.

Autopsies during 1943 were 25/132, or 19 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—An obstetrical service is not maintained in the hospital.

*Out-patient department.*—A member of the full-time medical staff is in charge as chief of the out-patient and reception service, assisted by one staff physician. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8:30 a. m. until 4 p. m., daily except Sunday; sick call is held twice daily for residents in the nearby home. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are filed in the department. The appointment system is utilized as a means of follow-up on patients.



*Pharmacy.*—The pharmacy in the hospital is supervised by a full-time, registered pharmacist. All pharmaceutical preparations used are of standard quality. Complete records are maintained of drug stock and prescriptions and narcotic supplies and records are checked regularly.

*Nursing.*—The nursing service is supervised by a full-time directress of nursing. There was a staff of 34 full-time and 1 half-time graduate nurses on duty at the time of survey, 22 of whom were in supervisory capacity and 12 plus the half-time nurse on general duty, allowing a nurse-patient ratio of about 1 to 9. Conferences of the nursing staff are held every 2 weeks, 9 months in the year, for the consideration of administrative and other matters. The nurses occupy a home which is of modern, fireproof construction.

There are, in addition to the graduate nurses, 63 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Three dietitians are employed in the organized dietary department of the hospital, two of whom are graduates of approved schools and members of the American Dietetic Association. The third member of the group is not a graduate of an approved school but is said to be certified by United States Civil Service as a qualified dietitian. Members of the staff are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical social-service department.*—One full-time, trained worker is employed in the department of medical social service. Social and financial investigations of patients are made when indicated and reports of these investigations are on file in the department. Discharged patients are followed up by means of home visits, telephone, and mail.

*Library.*—The medical library in the hospital consists of 296 current, standard texts and 21 medical periodicals are received monthly. The medical-records librarian is in charge.

*Residencies.*—Programs have not been formulated for graduate training in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The establishment of a full 4-year program in graduate training in surgery does not appear to be justified by the quantity of clinical material available in admissions to the hospital or the volume of surgery done; clinical material in the out-patient department is considerable, however. It is probable that the clinical material available could be utilized to advantage in the partial training of a resident during 1 or 2 years and particularly so in view of the fact that the chief of surgery and his assistant in general surgery, and the general surgical consultant, are fellows of the American College of Surgeons. Moderate interest in the subject of graduate training in surgery was expressed by the chief medical officer and the members of the surgical staff who were interviewed.

Among the points of importance if the establishment of a program of graduate training in general surgery is seriously considered in this hospital are: Clinico-pathological conferences at regular and frequent intervals as adjuncts to the general staff meetings for thorough review of the clinical work and instruction of residents; cross-indexing of the medical records according to operation; supervision of the clinical laboratory by a full-time, qualified physician; the number of autopsies performed, and the fact that special records are not made of anesthetics administered. It is recommended by the American College of Surgeons that in hospitals where graduate training programs are functioning or are contemplated, the incidence of autopsies should be at least 59 percent and as much more as possible. Of importance in the field of hospital standardization, in addition to the foregoing, are the comparatively high ratio of graduate nurses to patients and the qualification of the third member of the staff in the dietary department.

PAUL S. FERGUSON, M. D.

Director of Surveys.



## VETERANS' ADMINISTRATION HOSPITAL, BRONX, N. Y.

(Col. Robert C. Cook (Medical Corps), manager; Lt. Col. Harvey C. Hardegree, chief medical officer)

JANUARY 24, 25, 1945.

*General.*—This institution is owned by the United States Government and operated by the Veterans' Administration as a general hospital. It has an official bed capacity of 1,725 and there are 1,628 patients in the hospital today.

The physical plant consists of a main building of 14 stories and basement of brick, concrete-steel construction, which was completed in January 1941. A five-story administration building of similar construction is attached to the central unit. These two buildings are integrated with a five-story, brick-concrete building which was previously used for college dormitories and was taken over by the Veterans' Administration in 1940. Other buildings on the grounds consist of a nurses' home, doctors' residence, ambulance house, central heating plant, and separate laundry. All departments are well equipped and are maintained efficiently.

The administrative officer of the hospital is the manager, who is a physician. He is assisted by the chief medical officer. Members of the medical staff are either Reserve officers in the United States Army Medical Corps or physicians selected by the Veterans' Administration through civil service and assigned to this hospital by the Medical Director.

*Medical staff.*—The medical staff consists of 58 physicians and 3 administrative officers in addition to the 30 medical officers attached to the out-patient department and reception service. The following clinical services are organized with a chief in charge of each section: Medical, surgical, tumor, clinical laboratory, out-patient and reception, neuropsychiatric, eye, ear, nose and throat, and radiology.

There is a consulting staff of 10 specialists in the various branches of medicine and surgery. Some members of this group are on part-time basis and visit the hospital at regular intervals, while others are on call as the need arises. A complete list of medical officers and consultants is attached to the original report of survey.

A meeting of the medical staff is held every Saturday at 2 p. m. All members are required to be present except in cases of emergency or absence from the hospital. The character of these meetings varies through the 4 weeks in the month, consisting of a presentation of selected cases and a review of deaths and autopsies in the hospital, addresses by guest speakers, medical motion pictures, and a clinical pathological conference. Members of the tumor clinic meet three times a week and these conferences are attended by two consultants in malignant diseases. Complete minutes of the first and fourth meetings of the month are recorded. The attendance record is carefully checked and noted on the doctor's service record.

At present there are no residents or interns in the hospital.

*Medical records.*—The medical records department is organized under the direction of a qualified librarian who is assisted by a large corps of clerks. The histories, physical examinations, and progress notes are written by the ward officers and this information is supplemented by reports of consultants, the radiologist, and the pathologist. All records are prepared acceptably according to regulations of the Veterans' Administration and are promptly written for all patients admitted. There is not a record committee of the medical staff, but each chart is reviewed and checked in each department and by the chief medical officer before it is sent to the record room for filing. Charts are filed serially and indexed according to disease and operation. The standard nomenclature is used as a basis for recording final diagnoses.

*Diagnostic and adjunct facilities.*—The clinical laboratory, situated on the ground floor of the main hospital building, is fully equipped for all clinical, bacteriological, serological, and pathological examinations. A well-qualified staff of 10 trained technicians is maintained in this department, which is under the supervision of a full-time qualified pathologist. The large number of examinations reported indicates that this department is used extensively. All tissues removed at operation are examined and reported by the pathologist. Copies of laboratory reports are prepared in duplicate, one copy of which is filed on the patient's chart and the other in the department. One hundred autopsies were reported during 1944 representing 9 percent of deaths in the hospital for that period.

The X-ray department is located on the ground floor of building C and is fully equipped for diagnostic and therapeutic work. The equipment consists of six diagnostic units and a cystoscopic table with radiographic unit. The therapy equipment consists of three 200-kilovolt units, one 200-kilovolt unit, a 400-kilovolt unit and a portable 120-kilovolt unit used for superficial treatments. There are three well-trained radiologists and therapists attached to this department which also employs 10 full-time trained technicians. Reports of examinations and treatment on this service are prepared in duplicate, one copy of which is filed in the patient's chart and the other in the department. Complete monthly and annual reports are made of the work done.

The department of physical therapy is fully equipped and carries on an extensive program of treatment which requires employment of nine trained physical therapists. A medical officer is in part-time charge of this department. Records of treatments are made in duplicate; one copy is filed with the medical record and the other in the department.

*Surgical department.*—The operating rooms are modern and fully equipped and include four major and one minor operating rooms, a fracture room, and two cystoscopic rooms. Nine nurses and nine attendants are employed in the department. Physicians are always used as assistants in major operations. Evidence of preoperative study and a provisional diagnosis are recorded prior to all operations. A complete report of findings and technique is recorded soon after the operation and is signed by the surgeon. The sterilizers are modern in every respect and are checked with the recording thermometer.

The surgical service is supervised by a chief of department and heads of the various surgical specialties who are responsible, through the manager and the chief medical officer, to the Medical Director of the Administration for surgery done. Other factors in the control of surgery are the assignment of a surgeon to each case by the chief, who considers the medical officer competent to do the work; a complete work-up of the case with a preoperative diagnosis recorded prior to the operation, and the examination by the pathologist of all tissues removed in the operating rooms. Other members of the surgical staff are the ward medical officers, who are responsible for the care of patients under the supervision of their superior officers.

The department of anesthesia is under the direction of a qualified medical anesthetist and all anesthetics are administered by physicians. The types of anesthetics used are ether, nitrous oxide, local, spinal, ethylene, cyclopropane, and intravenous. A complete physical examination and urinalysis are made in all cases prior to operation and special records of anesthetics are prepared and attached to the patients' charts. Infections occurring postoperatively in clean surgical cases are recorded on the patients' medical records.

During 1944 there were 1,036 major and 683 minor operations performed in the hospital.

*Clinical material.*—This hospital maintains 1,725 beds and 1,628 patients are in the hospital today. Beds allotted to surgery are: 172 for general surgery, 39 for chest surgery, 86 for orthopedic surgery, 62 for urology, and 226 to the tumor service. There were 183 patients on the tumor service at the time of survey, including 48 in eye, ear, nose, and throat, and 46 women, the latter providing some gynecological surgery.

All of the wards are active and filled to capacity. There are 636 beds for general surgery and the surgical specialties, which comprise about one-third of the beds in the hospital. About one-third of the patients are veterans of the present war, hence the surgical service cares for patients of World War I and II, which widens the age group and the scope of surgery, including considerable plastic and reconstructive surgery.

The hospital is the designated tumor center of the eastern area and cancer patients are sent here from all New England States, the South, and from as far west as Pittsburgh. As a result this is an active service which has a daily average of close to 200 patients. There were 815 patients referred to the tumor clinic in 1944 and there were 598 patients in the follow-up clinic during the same period.

Out of the 9,843 patients admitted to the hospital last year the number assigned to general surgery and the surgical specialties was as follows: general surgery, 2,640; ophthalmology, 281; otolaryngology, 343; urology, 481; orthopedic surgery, 582; neurological surgery, 61; gynecology, 24; plastic surgery, 57; proctology, 571, and thoracic surgery, 73.

*Obstetrics.*—There is no obstetrical department in this hospital.

*Out-patient department.*—The out-patient department is combined with the reception service, which is staffed by a full-time chief and a large corps of medical



assistants. The activities of the out-patient department pertaining to reexamination of veterans for adjustment of compensation will be transferred to a location in downtown New York in the near future. The department will then care for patients in the usual out-patient sense and examine those to be admitted to the hospital.

*Pharmacy.*—The hospital pharmacy is under the supervision of a full-time, registered pharmacist and only pharmaceutical preparations of standard quality are used. Complete records of drug stock and prescriptions are maintained. Narcotic records and supplies are checked regularly. The personnel of this department includes seven trained pharmacists.

*Nursing.*—The nursing service is organized under the direction of a chief nurse. At the time of survey 212 graduate nurses were on duty, 16 in supervisory capacity and 196 on general duty. This hospital has been approved for the training of cadet nurses and 14 cadets were in training. There are 278 attendants employed, the majority of whom assist on the wards in the care of patients.

*Dietary department.*—The hospital maintains a fully equipped and well-organized dietary service. The chief dietitian is a university graduate and is registered and there are 10 graduate assistants in the department. No student dietitians are under instruction at this time, but a graduate course in dietetics is being instituted.

*Medical social-service department.*—This department is under the direction of a trained social worker, who has 14 trained assistants on her staff. Social investigations are made of cases when indicated, chiefly through social service agencies. Full reports of the case studies are on file with the patient's medical record and also in the department.

*Library.*—The hospital maintains a medical library of 431 current, standard texts and receives 27 medical journals monthly. A full-time, trained librarian is in charge of the library, which is conveniently located for use by the medical staff.

*Conclusions.*—1. This large hospital is fully equipped and well staffed in all departments. In addition to the regular, full-time medical staff, there are 10 New York City specialists on the consulting staff who visit the hospital periodically and give good support to the professional services. The regular and consulting medical staff members are well qualified to carry on a program of graduate training in surgery.

2. There is a fairly good volume and variety of clinical material for teaching purposes in this hospital, including veterans in a wide age group among those being treated.

3. The clinical laboratory, which makes about 500 tissue sections a month and does 100 autopsies a year, in addition to a large volume of chemistry, bacteriology and serology, is in position to offer some instruction in the basic medical sciences. Such courses could be supplemented by outside connections which the hospital has established. Dr. Fred Steward, pathologist at Memorial Hospital, New York City, and consulting pathologist to the veterans' hospital, probably could assist in the direction of a course in pathology and arrange for supplementary courses in the basic medical sciences outside the veterans' hospital.

4. The active tumor service, which averages about 200 patients daily, provides considerable good material for training in surgical diagnosis and surgery of malignant lesions.

5. This hospital has the advantage of being located in a medical center where residents in surgery could readily supplement their training and experience through affiliation with teaching institutions.

E. W. WILLIAMSON, M. D.,  
Assistant Director.

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#### VETERANS' ADMINISTRATION HOSPITAL, OTEEN, N. C.

(Dr. Frank B. Brewer, manager; Lt. Col. David E. Quinn, clinical director)

MAY 4, 1944.

*General.*—This is a hospital for tuberculosis patients, with an official bed capacity of 1,269. It will be noted that this is an increase of about 50 percent over the former official bed capacity. The physical plant consists of seven buildings, of two to four stories and basement, modern, fireproof construction. The equipment in all departments appears to be adequate for efficient diagnosis and treatment, and is of good quality.



The hospital is administered by a manager who is a physician, assisted by the clinical director. Members of the medical staff are either United States Civil Service or United States Medical Corps status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 27 active and 3 Dental Corps members is organized on the closed plan, the clinical director acting as chief of staff. There is fairly extensive departmentalization, with heads of departments and subdivisions, who are active in control of the clinical work. Of the two consultants, both practitioners in Asheville, one is a specialist in urological surgery, on part-time salary basis and who visits the hospital at regular intervals, while the other, a specialist in thoracic surgery, is on fee basis and is called to the hospital as the need arises.

The medical staff is said to meet regularly each week throughout the year for a review of the clinical work of the hospital, although only 40 weekly meetings had been held during the 12 months preceding the date of survey. The programs consist of consideration of clinical cases and deaths, review of X-ray films, diagnosis and discharges, and sometimes group studies. In addition to the weekly staff meetings, the collapse therapy board meets 6 days each week at which time some clinical cases are discussed. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist and radiologist. Minutes and attendance records of the general staff meetings are kept. Departmental meetings and clinicopathological conferences are not held.

There are no interns or residents on duty in the hospital at present.

*Medical records.*—The medical records are prepared by the staff medical officers and appear to be complete in all details. A full-time, trained librarian has charge of the completed records, assisted by a large corps of trained clerks. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease and operation is up to date. The cross-indexes are used by the medical staff to some extent for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well organized clinical and surgical pathological laboratories in which all types of laboratory procedures are carried out. The full-time pathologist, Dr. R. N. Brown, is qualified by training and experience and holds membership in a national pathological society. He is assisted by seven full-time, trained technicians, of whom two are registered. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The full-time roentgenologist, Dr. H. B. Williams, is qualified for his work by training and experience. A small group of trained, full-time technicians is employed.

The facilities for physical therapy in the hospital are limited due to the fact that physical therapy is not extensively employed in the treatment of tuberculous patients. The equipment conforms, however, to that usually found in institutions of this character and is supervised by Maj. S. S. Beverly, chief of the medical service. Seven full-time, trained technicians are employed and complete records of treatment are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major and one minor operating rooms, one cystoscopic room, sterilizing and workrooms. The various rooms are situated to best advantage and are said by the surgical staff to be adequate in extent for the present needs of the hospital. The supply of instruments for surgery and the treatment of tuberculosis is extensive in number and variety and is probably sufficient for any operation or procedure ordinarily performed by the surgical staff. Two graduate nurses and two orderlies are assigned to the department.

The full-time surgical staff consists of five members, supervised by the chief of surgery. The general and orthopedic surgery, and much of the urological surgery and bronchoscopic work, is done by the chief of department and two assistants, while the services of the consultant in urology are utilized to some extent in surgery and a staff specialist does some of the bronchoscopies; all operations in oral surgery are performed by the chief of the dental division. One staff specialist in ophthalmology-otolaryngology is responsible for all surgery in that combined specialty. It appears that the services of the consultant in thoracic surgery are seldom used as far as the actual performance of operations is concerned.

The chief of surgery is responsible, through the manager and the clinical director, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by members of the surgical staff, supervised by Dr. James D. Murphy, chief of the surgical service. All usual types of anesthesia are used including pentothal sodium; special records are not made of anesthetics administered. Full recording of the physical examination, diagnostic laboratory procedures and the provisional diagnosis is required before the administration of an anesthetic may begin.

Any infections occurring postoperatively in clean surgical cases are recorded in the office of the chief of surgery. In the event that a postoperative infection occurs, the incident is carefully investigated, an attempt made to determine the source of infection and corrective measures taken.

During the fiscal year ending April 30, 1944, there were performed in the hospital 170 major operations, of which 148 were thoracic, and 7,092 minor operations, of which 6,877 were thoracic, most of the latter probably being pneumothorax refills. Records as to the nature of these operations, collectively or their division into general and specialized surgery, were not available for review. Since there are no residents in the hospital, the statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability as demonstrated.

*Clinical material.*—Male veteran patients are admitted whose primary diagnosis is tuberculosis, and secondary conditions of medical or surgical nature, naturally arise during hospitalization. Few female patients are admitted, although those of veteran classification are eligible for treatment. Provision is not made for the accommodation of patients with communicable diseases, but ample means for segregation and isolation make possible the care of such patients when the need arises. There are 97 beds for surgical patients of all types, chiefly for those with conditions related to tuberculosis. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During the fiscal year ending April 30, 1944, the average daily census of the hospital was 739, but there were 1,027 patients in the hospital on the date of survey. In the foregoing period 1,583 patients were admitted, all with a provisional diagnosis, at least, of tuberculosis. Further differentiation of the patients admitted into clinical services is not possible due to the fact that admissions are through the reception out-patient department to the diagnostic service and cases are thoroughly worked up before the diagnosis is announced. The nearest possible approximation of surgical patients among those admitted is said to be the number of operations performed, given elsewhere.

In the out-patient department during the fiscal year ending April 30, 1944, 339 individuals were given 885 treatments, and 648 patients were subjected to 5,039 examinations, the latter probably chiefly for rating purposes.

Autopsies during the fiscal period previously mentioned were  $15\frac{1}{2}$ , or 8 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—An obstetrical service is not maintained in the hospital.

*Out-patient department.*—The out-patient and reception service is staffed by chief of service and assistants. Extremely few out-patients, in the usual sense, are treated inasmuch as the service is almost exclusively for patients for pneumothorax refills and for rating purposes. Patients are received for examination and treatment at practically any time between 8:30 a. m. and 4:00 p. m., 6 days in a week. Complete records of patient visits, physical findings and treatment administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—The hospital pharmacy is supervised by a full-time, registered pharmacist. All pharmaceutical preparations used are of standard quality. Complete records of prescriptions and drug stock are maintained, and narcotic supplies and records are checked regularly.



*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 101 graduate nurses on duty at the time of survey, 25 of whom were in supervisory capacity and 76 on general duty, allowing a nurse-patient ratio of about 1 to 7½ on the basis of the 1943-44 average daily census, and about 1 to 10 on the basis of the number of patients in the hospital on the date of survey. Conferences of the entire nursing staff are held weekly throughout the year for the consideration of administrative and other matters. The nurses occupy a home which is of modern, fireproof construction.

There are, in addition to the graduate nurses, 162 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Eight dietitians are employed in the organized dietary department of the hospital. All members of the group are graduates of approved schools and the chief and three assistants are members of the American Dietetic Association; two assistants are recent graduates and not yet eligible for registration. Members of the departmental staff are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—One full-time, trained worker is employed in the department of medical social service. Social and financial investigations of patients are made when indicated and full reports of these investigations are on file in the patients' medical records and in the department. Discharged patients are followed up by means of home visits and mail.

*Library.*—The hospital maintains a medical library of 385 current, standard texts and receives 24 medical periodicals monthly. A full-time librarian is in charge of the library.

*Residencies.*—Plans have not been drawn up for graduate training programs in general or thoracic surgery. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—Clinical material in admissions to the hospital and out-patient department, and the volume of surgery done appear to qualify this institution as a center for graduate training in thoracic surgery. The medical staff as a whole, and the surgical staff in particular, are well organized and administered, providing good supervision for the work of residents. Administrative officers and members of the surgical staff interviewed expressed keen interest in the possibility of a graduate training program being established in the hospital. The chief of surgery and the consultant in thoracic surgery are Fellows of the American College of Surgeons.

Among the points which should have special consideration if a program of graduate training in surgery is to be established in the institution are: Surgical departmental meetings and clinicopathological conferences at regular and frequent intervals, to insure adequate review of the clinical work for the training and experience of residents; the autopsy percentage, which, to fulfill the recommendation of the American College of Surgeons for hospitals where graduate training programs are functioning or are contemplated, should be at least 50 percent and as much more as feasible. In addition to the foregoing, the fact that special records are not made of anesthetics administered and the comparative high ratio of nurses to patients, are of importance in the field of hospital standardization.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*

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VETERANS' ADMINISTRATION HOSPITAL, DAYTON, OHIO

(Lt. Col. E. N. Schillinger, chief medical officer; Mr. John H. Ale, manager)

MAY 30, 1944.

*General.*—This is a general hospital with an official bed capacity of 1,054. The physical plant consists of four buildings, of three to seven stories, modern, fireproof construction. The equipment in all departments appears to be adequate for efficient diagnosis and treatment and is of good quality.

The hospital is administered by a manager who is a layman, assisted by the chief medical officer and a clinical director. Members of the medical staff are



on either United States Army Medical Corps or United States Civil Service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 37 active and 4 Dental Corps members is organized on the closed plan, the chief medical officer acting as chief of staff. There is fairly extensive departmentalization, with heads of departments and subdivisions who are active in control of the clinical work.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The program consists of consideration of admissions and diagnoses, clinical cases and deaths in general, and autopsy material, and sometimes there is a guest speaker in addition. Over-all medical and surgical departmental meetings are held weekly throughout the year. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist and radiologist. Minutes and attendance records of the general staff meetings are kept. There are also two weekly meetings of the tumor board and the surgical collapse board, and one weekly meeting of the fever therapy board. Special clinicopathological conferences are not held.

There are no interns or residents on duty in the hospital at present.

*Medical records.*—The medical records are prepared by the staff medical officers and appear to be complete in all essential details. A full-time, trained librarian has charge of the completed records, assisted by a large corps of trained clerks. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease and operation is up to date. The cross-indexes are used to some extent by members of the medical staff for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has a fully equipped and well-organized clinical and surgical pathological laboratory in which all types of laboratory procedures are carried out. The full-time pathologist, Maj. William Abramson, is qualified by training and experience. He is assisted by eight full-time, trained technicians, of whom two are registered. All tissues removed at operations are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The full-time roentgenologist, Maj. A. J. Brogan, has good, formal qualifications. Four full-time, trained technicians are employed, two of whom are registered.

The facilities for physical therapy in the hospital are complete, and are supervised by Dr. A. J. Eisenberg, a member of the staff of the department of medicine. Five full-time trained technicians are employed, of whom two are registered, and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of three major operating rooms, a cystoscopic room in the roentgenological department, a fracture room, sterilizing and work rooms. The various rooms appear to be situated to good advantage and to be adequate in extent for the present size of the hospital. The supply of surgical instruments seems to be sufficient in number and variety for any type of operation the surgeons may be called upon to perform. Four graduate nurses and four orderlies are assigned to the department. The full-time general surgical staff consists of seven members, supervised by the chief of surgery. The general and allied specialized surgery is done by members of the full-time staff without much specialization, except that a fair portion of the urological surgery is done by the specialist in that division. There is a separate surgical division of ophthalmology-otolaryngology, staffed by a chief of division and two assistants. Members of the division divide the surgery in their combined specialty among them.

The chief of surgery and the chief of ophthalmology-otolaryngology are responsible, through the manager and chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in their responsibility, however. Additional means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed-staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by members of the surgical staff, and are supervised by Capt. M. P. Rhodes, staff surgeon. The usual types of anesthesia are used, including cyclopropane, avertin, and pentothal sodium; nitrous oxide is not used to any extent, however. Special records are

made of anesthetics administered but no postanesthetic notations were noted in examining the medical records. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

Any infections occurring postoperatively in clean surgical cases are recorded in the office of the chief of surgery. In the event that a postoperative infection occurs, the incident is carefully investigated, an effort made to ascertain the source of infection, and corrective measures taken.

During the year 1943 there were 519 major and 662 minor operations performed in the hospital, including 52 major and 80 minor in ophthalmology-otolaryngology. Records as to the nature of these operations, collectively, or their divisions into general and specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have performed a limited number of major and minor operations under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery, while female patients are admitted chiefly for gynecological conditions. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. There are 2,940 beds in the adjacent domiciliary home, the occupants of which are hospitalized in this hospital. The following beds are allotted for surgical patients: 113 for general surgical patients, 19 for gynecology, 67 for orthopedic surgery, 64 for utological surgery, and 65 for ophthalmology-otolaryngology. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During the year 1943 the average daily census in the hospital was 781, and 4,883 patients were admitted. A division of patients admitted into clinical services is not available due to the fact that patients are admitted through the reception out-patient department to the diagnostic service and thoroughly worked up before the diagnosis is announced. It was stated that the closest approximation possible of surgical patients is the number of operations performed, which is 519 major and 662 minor operations.

In the out-patient department during 1943, for purely out-patient purposes, 14,680 individuals were given 50,547 treatments, and 15,545 individuals were subjected to 26,347 examinations, the latter probably for rating purposes.

Autopsies during 1943 were 202/397, or 51 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—Obstetrical patients are not cared for in the hospital.

*Out-patient department.*—The reception out-patient department is staffed by a chief of service and five assistants. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8 a. m. until 4:45 p. m., daily except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up of patients.

*Pharmacy.*—The hospital pharmacy is supervised by a full-time, registered pharmacist. All pharmaceutical preparations used are of standard quality. Complete records of drug stock and prescriptions are maintained, and narcotic supplies and records are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 85 graduate nurses on duty at the time of survey, 25 of whom were in supervisory capacity and 61 on general duty, allowing a nurse-patient ratio of about 1 to 9. Conferences of the entire nursing staff are held on an average of once weekly throughout the year for the consideration of administrative and other matters. The nurses occupy two homes, which are of modern, fireproof construction. Arrangements were being made at the time of survey for the establishment of a school of nursing for cadet nurses. It was expected that the school would be in operation within 2 months of that date.

There are, in addition to the graduate nurses, 266 subsidiary workers on duty who are active in the care of patients in the hospital.



*Dietary department.*—Four dietitians are employed in the organized dietary department of the hospital. All of the dietitians are graduates of approved schools and members of the American Dietetic Association. Members of the department are active in consultation with staff physicians and in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—Two full-time, trained workers are employed in the department of medical social service. Social and financial investigations are made of patients when indicated and full reports of these investigations are on file in the patients' medical records and in the department. The social workers follow up discharged patients by means of home visits, mail, and the various investigative agencies in the vicinity.

*Library.*—The medical library in the hospital consists of 680 current, standard texts and 24 medical periodicals are received monthly. A full-time librarian has charge of the medical library.

*Residencies.*—Plans have not been drawn up for graduate training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The Veterans' Administration hospital in Dayton appears to present good possibilities as a center for graduate training in general surgery, inasmuch as the clinical material in admissions to the hospital and out-patient department, and the volume of surgery done, are sufficient for that purpose. The medical staff is well organized and members of the surgical staff interviewed appear to be high-class, interested men. The chief medical officer, clinical director, and the chief of surgery expressed deep interest in the subject of graduate training and the possibility of being authorized to train surgical residents in the hospital. The chief of surgery is a fellow of the American College of Surgeons.

The points of importance to be considered in connection with the establishment of graduate training programs in this hospital are, the holding of special clinico-pathological conferences at regular and frequent intervals to insure thorough review of the clinical work, and supervision of the surgical and medical pathological laboratories by a full-time, qualified pathologist. Of importance in the field of hospital standardization, in addition to the above, is the comparatively high ratio of graduate nurses to patients.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*

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#### VETERANS' ADMINISTRATION HOSPITAL, PORTLAND, OREG.

(Lt. Col. Paul I. Carter, manager; Lt. Col. Leo M. Maguire, chief medical officer)

FEBRUARY 19, 1945.

*General.*—This is a general hospital with an official bed capacity of 416. The physical plant consists of 3 buildings, of 3 to 6 stories and basement, modern, fire-proof construction. The buildings appear to be adequate for the number of patients being accommodated at present. The equipment in all departments seems to be of sufficient extent and variety for good diagnosis and treatment and is of good quality; space allotted to certain of the diagnostic departments is entirely inadequate, however, as noted farther along in this résumé.

The hospital is administered by a manager who is a physician, assisted by a chief medical officer. Members of the medical staff are on either United States Army Medical Corps or United States Civil Service status and are assigned to this hospital by the Medical Director of the Veterans' Administration; consultants are appointed by the Medical Director on joint nomination of the manager and chief medical officer. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 19 active and 2 Dental Corps members is organized on the closed plan, the chief medical officer acting as chief of staff. There is basic departmentalization, with heads of departments and subdivisions who are active in control of clinical work. There is a consulting staff of 8 members, comprising an outstanding group of clinicians and specialists of the city, some of whom are members of the faculty of the nearby medical school of the University of Oregon. Members of the consulting staff are chiefly on part-time salary basis.



The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. Programs consist of consideration of clinical cases and deaths, tissue specimens and autopsy material, and medical subjects having a bearing on the care and treatment of patients, with, sometimes, administrative matters in addition. Over-all medical and surgical departmental meetings are held weekly throughout the year. These meetings appear to afford an adequate review of the clinical work and are regularly attended by the pathologist and radiologist. Minutes and attendance records for the general staff meetings are kept.

There are at present no residents or interns in the hospital.

*Medical records.*—The medical records are in the care of a full-time, trained librarian, who is assisted by a fairly large group of trained clerks. The records are prepared by the staff medical officers and appear to be complete in all details. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease is up to date. The cross-indices, as to disease, are used to some extent, by the medical staff for group studies. Cross-indexing as to operations has not been developed.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped clinical and surgical pathological laboratories, in which all types of laboratory procedures are carried out. The space allotted to the department is, however, entirely inadequate to carry on efficient work in an expeditious manner. The consulting pathologist, Dr. Frank R. Menne, is well qualified and spends a total of 20 hours weekly in the department. He is assisted by a small group of full time, trained technicians, most of whom are registered with the national registry. All tissues removed at operation are examined and full reports rendered.

The radiological department is well equipped with radiographic, fluoroscopic, and deep therapeutic apparatus, and 100 milligrams of radium is available for use. The full-time radiologist, Maj. Milton D. Hyman, is fully qualified. He is assisted by a small group of full-time, trained technicians, one of whom is registered. As noted heretofore, this department occupies quarters that are small and cramped. They should be increased by at least 50 percent if prompt and efficient service is to be rendered to patients and the medical staff.

The facilities for physiotherapy in the hospital are quite complete and are supervised by Capt. E. W. Fowlks, the full-time physiotherapy officer. Two full-time, trained technicians are employed, and treatment records, which are maintained in the department, are complete.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major and one minor operating room, a cystoscopic room in the radiological department, sterilizing and work rooms. The operating rooms are situated to the greatest advantage and appear to be adequate in extent and equipment for the present size of the hospital. The supply of surgical instruments seems to be sufficiently large in number and variety for any type of operation usually performed in the hospital. Four graduate nurses and two orderlies are assigned to the department.

The full-time general surgical staff consists of six members, supervised by the chief of surgery. General and allied specialized surgery is done by members of the full-time staff without much specialization, and it appears that the services of the surgical consultant are seldom utilized as far as the actual performance of operations is concerned. There is a separate division of ophthalmology-otolaryngology, staffed by the chief of division, who does all the surgery in that combined specialty.

The chiefs of surgery and of ophthalmology-otolaryngology are responsible, through the manager and chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; their assisting surgeons necessarily share in their responsibility, however. Other means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by staff physicians and are supervised by the chief of surgery, Dr. George E. Pfeiffer. The usual types of anesthesia are used, including cyclopropane, avertin, and pentothal sodium; special records are made of anesthetics administered, and there are some postanesthetic notations recorded. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

Any infections occurring postoperatively in clean surgical cases are recorded in the office of the chief of surgery. In the event that an infection occurs, the inci-

dent is investigated, an attempt made to determine the source of infection, and corrective measures taken.

During the year 1944 there were 554 major and 398 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeon will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Both male and female veteran personnel are admitted in all branches of medicine and surgery. There are 148 beds for all types of surgical patients, but further division, for the surgical specialties, is not made. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

The average daily census in the hospital during 1944 was 352, and 2,843 patients were admitted. An exact division of patients admitted into clinical services is not available due to the fact that patients are admitted through the reception out-patient department to the diagnostic service and thoroughly worked up before the diagnosis is announced. However, an approximate division shows the following as surgical patients: 631 in general surgery, 46 in ophthalmology, 61 in otolaryngology, 193 in urological surgery, 185 in orthopedic surgery, 75 in neurological surgery, 3 in gynecology, 66 in plastic surgery, 59 in thoracic surgery; acute fractures admitted numbered 73, and there were 17 open reductions performed among them.

In the out-patient department during 1944, for purely out-patient purposes, a total of 4,350 patients was admitted. A record of the out-patient visits as to clinical services was not available.

Autopsies during 1944 were 69/299, or 23 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—The hospital does not maintain an obstetrical service.

*Out-patient department.*—The out-patient and reception service is supervised by a member of the full-time medical staff and four additional members of the full-time staff are on assignment to that department. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8:30 a. m. until 4:30 p. m., daily except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—A full-time, registered pharmacist has charge of the hospital pharmacy. All pharmaceuticals used are of standard quality. Complete records are maintained of drug stock and prescriptions, and the records and supplies of narcotics are checked at regular intervals.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. At the time of survey a staff of 51 graduate nurses was on duty, 21 of whom were in supervisory capacity, and 30 general-duty nurses, providing a nurse-patient ratio of about 1 to 7. Conferences of the graduate nursing staff are held monthly for the consideration of administrative and other matters. The nurses occupy a home that is of modern, fireproof construction.

There was, at the time of survey, a staff of 53 subsidiary workers assisting the graduate nurses in the care of patients in the hospital.

*Dietary department.*—Three dietitians are employed in the organized dietary department in the hospital, all of whom are graduates of approved schools and members of the American Dietetic Association. Members of the department are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—One full-time, trained worker is employed in the department of medical social service. Investigations of social conditions among patients are made and full reports of these investigations are on file in the patients' medical records and in the department. Follow-up of discharged patients, insofar as is possible with but one worker in the department, is carried on through home visits, mail and Red Cross chapters over the country.



*Library.*—The medical library in the hospital consists of 240 current, standard texts and 19 medical periodicals are received monthly. A part-time librarian has charge of the medical library.

*Residencies.*—Plans have not been drawn up for a graduate training program in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The Veterans' Administration hospital at Portland appears to present good possibilities for graduate training in general surgery, inasmuch as the clinical material in admissions to the hospital, out-patient material, and the volume of surgery done should be sufficient for the training of residents. Whether or not the available material would be adequate for a 7-year residency is problematical, however. The hospital and medical staff are well organized for teaching purposes and every staff physician contacted during the visit to this institution expressed deep interest in graduate training. The fact that the hospital is the tumor center for the west coast, with a very active and well-patronized clinic, which meets weekly throughout the year, adds materially to its importance as a training center. It is probable that the authorities of the nearby medical school of the University of Oregon would readily cooperate in any program of graduate training established in the hospital.

The points of importance which should have consideration in connection with the establishment of graduate training programs in this hospital are: The lack of cross-indexing of the medical records according to operation; the urgent need for additional space in the clinical laboratory and radiological departments; the giving of additional time to the clinical laboratory by the consulting pathologist if possible, and the autopsy percentage. It is recommended by the American College of Surgeons that, in institutions where graduate training programs are functioning or are under consideration, the autopsy percentage be at least 50 percent and as much more as possible. The foregoing points are worthy of consideration in connection with hospital standardization, as well.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*

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#### VETERANS' ADMINISTRATION HOSPITAL, ASPINWALL, PA.

(Col. K. A. Carroll (MC), manager; Dr. Marshall L. McClung, clinical director)

AUGUST 17, 1944.

*General.*—This is a general hospital with an official bed capacity of 767 and an emergency expansion capacity of 1,137 by moving in bed centers, occupying the solaria, etc. On the date of survey a shortage of graduate nurses and subsidiary help had necessitated the closing down of several wards, leaving a total of 655 beds in use. The physical plant consists of two buildings of two to four stories and basement, modern, fireproof construction. The equipment in all departments appears to be adequate for efficient diagnosis and treatment, and is of good quality.

The hospital is administered by a manager who is a physician, assisted by the clinical director. Members of the medical staff are on either United States Army Medical Corps or United States civil-service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 34 active and 4 Dental Corps members is organized on the closed plan, the clinical director acting as chief of staff. There is fairly extensive departmentalization with departmental heads who are active in control of the clinical work. A consulting staff of five members consists of medical and surgical specialists from Pittsburgh. Some members of the latter group are on part-time salary basis and visit the hospital regularly, while others are on fee basis and are called as the need arises.

The medical staff meets each week throughout the year for a review of the clinical work of the hospital. The program consists of the consideration of clinical cases and deaths, autopsy material, and occasionally administrative business. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist and radiologist. Minutes and attendance records of the general meetings are kept. In addition to the weekly staff meetings, there is a monthly meeting of the hospital "clinical society" 8 months in the year for the presentation of medical papers, discussion



of medical subjects, guest speakers, etc. Departmental meetings and clinicopathological conferences are not held.

There are at present no interns or residents on duty in the hospital.

*Medical records.*—The medical records are prepared by the staff officers and appear to be complete in essential details. A full-time librarian, assisted by a small corps of trained clerks, has charge of the completed records. Filing is by serial number, recognized nomenclatures are used, and cross indexing according to disease is up to date. The cross indexes, as far as developed, are used to some extent by the staff officers for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well-organized clinical and surgical pathological laboratories in which all types of laboratory procedures are carried out. The full-time pathologist, Dr. Fred Eberson, is qualified by training and experience, and is assisted by seven full-time, trained technicians, of whom two are registered. All tissues removed at operation are examined and full reports rendered.

The radiological department is equipped with radiographic and fluoroscopic apparatus. The full-time roentgenologist, Dr. C. F. Bloom, is qualified by training and experience. Two full-time, trained technicians are employed.

The facilities for physical therapy in the hospital are complete and are supervised by Capt. Louis Nathan, the staff orthopedist. Five full-time, trained technicians, of whom one is registered, are employed and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major and two minor operating rooms, a cystoscopic room, sterilizing and work rooms. The various rooms are situated to good advantage and are said by the surgical staff to be adequate in extent for the present needs of the institution. The supply of surgical instruments is extensive in number and selection and undoubtedly fill the needs of the staff surgeons. Four graduate nurses and five orderlies are assigned to the department.

The full-time staff in general surgery and the allied specialties consists of four members, supervised by the chief of surgery. The chief of department and one assistant perform all operations in general surgery, while there is specialization by one member of the group in each orthopedic and urological surgery. The two specialists in ophthalmology-otolaryngology are also supervised by the chief of surgery. Both members of this division do some of the surgery in ophthalmology and otolaryngology but the chief of division does ophthalmological surgery chiefly, while his assistant is chiefly concerned with that in otolaryngology. The services of the consultants in thoracic, urological, and neurosurgery are seldom utilized as far as the actual performance of operations is concerned.

The chief of surgery is responsible, through the manager and clinical director, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by staff physicians, supervised by Capt. L. J. Fronduti, a member of the surgical staff. The usual types of anesthesia are used, including pentothal sodium and avertin; special records are not made of anesthetics administered. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

Infections occurring postoperatively in clean surgical cases are recorded in patients' medical records, whereas, there should be a complete, centralized record in the office of the chief of surgery or elsewhere in the hospital concerning the incidence of infections, the investigative procedures followed, and the corrective measures taken.

During the year 1943 there were 753 major and 1,381 minor operations performed in the hospital. A review of the major operations reveals that 533 were of general nature, 18 were in thoracic surgery, 9 in neurological surgery, 96 in urological, and 67 in orthopedic surgery, and 30 in ophthalmology-otolaryngology. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrange-

ment will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery, while, at present, female veterans are admitted only in emergency. Facilities are provided for patients with communicable diseases and ample provision is made for segregation and isolation. There are 69 beds allotted to general surgical patients, 25 beds for orthopedic surgery, 30 beds for urological surgery, and 10 beds for ophthalmology-otolaryngology. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 681, and 4,569 patients were admitted. A division of the admissions into clinical services is not available due to the fact that patients enter through the reception out-patient department to the diagnostic service and are thoroughly worked up before the diagnosis is announced. The nearest possible approximation of surgical patients among those admitted is said to be the number of operations performed, which is 753 major and 1,381 minor.

In the out-patient department during 1943, 10,938 treatments were administered to 2,464 patients and 4,612 individuals were subjected to 20,222 examinations, the latter probably chiefly for rating purposes.

Autopsies during 1943 were 82, 313 or 26 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—An obstetrical service is not maintained in the hospital.

*Out-patient department.*—The out-patient and reception department is staffed by a chief of service and several assistants. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8:30 a. m. until 5 p. m., daily except Sunday. Complete records of visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are filed in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—A full-time, registered pharmacist has supervision of the hospital pharmacy. Only pharmaceutical preparations of standard quality are used. Complete records of drug stock and prescriptions are maintained and narcotic supplies and records are checked regularly.

*Nursing.*—The nursing service is supervised by a full-time directress of nursing. There was a staff of 70 graduate nurses on duty at the time of survey, 23 of whom were in supervisory capacity and 47 on general duty, allowing a nurse-patient ratio of about 1 to 9½. Conferences of the nursing supervisors are held monthly for the consideration of administrative and other matters. The nurses occupy homes that are of modern, fireproof construction. Note that a school of nursing for cadet nurses, 30 in number, is to open on September 1, 1944.

There are, in addition to the graduate nurses, 100 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Three dietitians are employed in the organized dietary department of the hospital. All are graduates of approved schools and the chief and one assistant are members of the American Dietetic Association. Members of this staff are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—One full-time, trained worker is employed in the department of medical social service. Social investigations of patients are made when indicated and full reports of investigations are filed in the patients' medical records and in the department. Discharged patients are followed up by means of home visits, mail, telephone, and other local investigative agencies.

*Library.*—The hospital maintains a medical library of 386 current, standard texts and receives 20 medical periodicals monthly. A full-time librarian is in charge.

*Residencies.*—Plans have not been drawn up for graduate training in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The volume of clinical material in admissions to the hospital and the out-patient department, and the volume of surgery done, appear to present good possibilities for graduate training in general surgery. Changes in the ad-



ministration were impending at the time of survey, but the officers then in charge and the members of the surgical staff interviewed were deeply interested in the possibility of training residents in surgery. The chief of surgery and the consultants in thoracic and neurosurgery are Fellows of the American College of Surgeons.

The points of importance to be considered in connection with graduate training in this hospital are: the holding of departmental meetings and/or clinicopathological conferences to insure adequate review of the clinical work and for the instruction of residents; cross-indexing of the medical records according to operation; complete and centralized recording of infections occurring in clean surgical cases; the incidence of autopsies. It is recommended by the American College of Surgeons that, in hospitals where graduate training programs are functioning or are contemplated, the autopsy percentage should be at least 50 percent and as much more as possible. Of importance in the field of hospital standardization, in addition to the foregoing are, the fact that special records are not made of anesthetics administered and the comparatively high ratio of graduate nurses to patients.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*

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VETERANS' ADMINISTRATION HOSPITAL, COLUMBIA, S. C.

(Dr. Jackson F. Woods, chief medical officer; Mr. S. C. Groeschel, manager.)

MAY 1, 1944.

*General.*—This is a general hospital with an official-bed capacity of 606, although about 800 beds were set up and ready for use on the date of survey. The physical plant consists of three buildings, of three to four stories and basement, modern, fireproof construction. The equipment in all departments appears to be adequate for good diagnosis and treatment, and is of good quality.

The hospital is administered by a manager who is a layman, assisted by the chief medical officer. Members of the medical staff are on United States Civil Service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 16 active and 2 Dental Corps members is organized on the closed plan, the chief medical officer acting as chief of staff. There is basic departmentalization with department heads who are active in the control of clinical work. The consulting staff of seven members comprises a group of local medical and surgical specialists, the members of which have been selected on the basis of their training and ability. Members of the consulting staff are said to be on fee basis and are called to the hospital as the need arises.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The program consists of consideration of clinical cases and deaths, autopsy material, papers on medical subjects, and sometimes administrative matters. These meetings appear to afford a fairly adequate review of the work, are regularly attended by the pathologist, and to less extent by the radiologist. Minutes and attendance of the general staff meetings are kept. Departmental meetings or clinicopathological conferences are not held.

There are no residents or interns on duty in the hospital.

*Medical records.*—Medical records are prepared by the staff medical officers and appear to be complete in all essential details. A full-time, trained librarian has charge of the completed records and is assisted by a large corps of trained clerks. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease is up to date. It appears that the indexes are little used by the medical staff for group studies or other purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped clinical and surgical pathological laboratories, in which all types of laboratory procedures are carried out. The full-time pathologist, Dr. R. N. Barnett, is qualified by training and experience. He is assisted by three full-time, trained technicians of whom one is registered. All tissues removed at operation are examined and full reports rendered.

The radiological department is well equipped with radiographic, fluoroscopic, and superficial therapeutic apparatus. The hospital was without a radiologist at the time of survey and each of the staff physicians was making his own interpretation of films and signing reports. It was stated that every effort was being



made to employ a staff radiologist. Two full-time, trained technicians are employed in the department.

The facilities for physiotherapy in the hospital are fairly complete and are supervised by a member of the staff of the department of medicine. Two full-time, trained technicians are employed and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of three major operating rooms, a plaster room, a cystoscopic room in the roentgenological department, sterilizing and work rooms. The various rooms seem to be situated to best advantage and are said to be adequate in extent for the present size of the hospital. The supply of surgical instruments is extensive and appears to be sufficient for any type of operation performed by the surgical staff. Three graduate nurses and one orderly are assigned to the department.

The full-time surgical staff consists of three members, supervised by the chief of surgery. Much of the general, orthopedic, and urological surgery is done by members of the full-time staff without much specialization, and the smaller portion of the surgery in urology and orthopedics is done by specialists of the consulting staff. The one staff specialist in ophthalmology-otolaryngology, who is under the supervision of the chief of surgery, performs all operations in that combined specialty.

The chief of surgery is responsible, through the manager and the chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered by members of the surgical staff and are supervised by Dr. Sidney Lipton, a member of that staff. All usual types of anesthesia are used, including pentothal sodium, the use of spinal, local, and pentothal sodium predominating. Special records of anesthetics administered are not made.

A record of infections occurring postoperatively in clean surgical cases is kept in the office of the chief of surgery. In the event that a postoperative infection occurs, the incident is carefully investigated, an attempt made to trace the infection to its source, and corrective measures taken.

During year 1943 there were 236 major and 667 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all branches of medicine and surgery, but few female patients are admitted, although they are eligible for admission. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such cases when the need arises. The number of beds for patients in general surgery and the surgical specialties is variable and a satisfactory estimate as to the division of these beds, or of the total number for surgical patients, could not be secured. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 399, and 3 678 patients were admitted. A division of patients admitted into clinical services is not available, due to the fact that those admitted are thoroughly worked up in the diagnostic service before the diagnosis is announced. The nearest possible approximation of surgical admissions is said to be the number of operations given, which is 236 major and 667 minor.

In the out-patient department during 1943, for purely out-patient services, 543 patients were given 1 028 treatments, and 2 855 individuals were given 7 361 examinations, the latter probably for rating purposes.

Autopsies during 1943 were 51/187 or 27 percent. Complete protocols are on file in the clinical laboratory for all autopsies performed.

*Obstetrics.*—The hospital does not maintain an obstetrical service.

*Out-patient department.*—The out-patient and reception service is supervised by a member of the full-time medical staff and one assistant. While the department is chiefly for rating purposes and few out-patients are treated in the usual sense, patients in both categories are seen from 8:30 a. m. until 4 p. m. daily except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—The hospital pharmacy is supervised by a full-time, registered pharmacist. All pharmaceutical preparations used are of standard quality. Complete records are maintained on drug stock and prescriptions, and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 66 graduate nurses on duty at the time of survey, 15 of whom were in supervisory capacity and 51 on general duty, allowing a nurse-patient ratio of about 1 to 6. Conferences of the entire nursing staff are held irregularly, on call, for the consideration of administrative and other matters. The nurses live in a home that is of modern, fireproof construction.

There are, in addition to the graduate nurses, 81 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Five dietitians are employed in the organized dietary department of the hospital. All of them are graduates of approved schools of dietetics and the chief of the group is a member of the American Dietetic Association; two of the assistants are recent graduates and not yet eligible for registration. Members of the department are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation and supply rooms were visited and found to be in sanitary condition.

*Medical social-service department.*—One full-time, trained worker is employed in the department of medical social service. Social and financial investigations of patients are made when needed and full reports of these investigations are on file in patients' medical records and in the department. The follow-up of discharged patients is conducted by means of home visits and mail.

*Library.*—The medical library in the hospital consists of 186 current, standard texts and 23 medical periodicals are received monthly. A full-time librarian has charge of the medical library.

*Residencies.*—Plans have not been drawn up for graduate training in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The Veterans' Administration hospital in Columbia appears to have some possibilities as a training center for graduate training in general surgery, inasmuch as the clinical material in total admissions to the hospital seems to be adequate for that purpose. Clinical material in admissions to the out-patient department is negligible and the volume of surgery done indicates that the treatment of patients by surgery is distinctly on the conservative side. It is problematical, therefore, whether or not this institution can take any considerable part in the over-all program of graduate training in the veterans' hospitals but it should have consideration as a part of the entire picture. The acting chief medical officer at the time of survey and members of the medical staff interviewed expressed only mild interest in the subject of graduate training in surgery.

Among the points of importance that should have consideration if a graduate training program is established in the hospital are: Departmental meetings of the medical staff and/or clinicopathological conferences, to insure adequate review of the clinical work; cross-indexing of the medical records according to operation; qualified, full-time, physician specialists in charge of the clinical laboratory and X-ray departments, and the incidence of autopsies. The American College of Surgeons recommends that, in a hospital where graduate training programs are functioning or are contemplated, the autopsy rate be at least 50 percent and as much higher as possible. The foregoing points are also of importance in the field of hospital standardization.

PAUL S. FERGUSON, M. D.,

Director of Surveys.



## VETERANS' ADMINISTRATION HOSPITAL, MEMPHIS, TENN.

(Dr. H. C. Dodge, manager; Lt. Col. Joseph E. Wheeler, clinical director)

MARCH 13, 1944.

*General.*—This is a general hospital with an official bed capacity of 440. The physical plant consist of a two to six stories and basement, modern, fireproof building. It was stated by the manager that 125 beds have been added to the capacity of the hospital, by moving in bed centers, but have not yet been put into use due to lack of nursing personnel. These beds are not included in the capacity reported above. The equipment in all departments appears to be adequate for efficient diagnosis and treatment, and is of good quality.

The hospital is administered by a manager who is a physician, assisted by a clinical director. Members of the medical staff are on either United States civil service or United States Army Medical Corps status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 13 active and 2 Dental Corps members is organized on the closed plan, the clinical director acting as chief of staff. There is basic departmentalization with department heads who are active in control of the clinical work. The two consultants are local surgical specialists, one in urology and one in ophthalmology-otolaryngology. The members of this group are on part-time salary basis, visit the hospital regularly and their services are freely used in performing operations in their specialties.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The program consists of consideration of clinical cases in general review, diagnosis and treatment, deaths and autopsy material. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist-radiologist. Minutes and attendance records of the general-staff meetings are kept. Departmental meetings and clinicopathological conferences are not held.

There are no interns or residents on duty in the hospital at present.

*Medical records.*—A full-time, trained librarian has charge of the completed medical records, assisted by a large corps of trained clerks. The records are prepared by the staff medical officers and appear to be complete in all essential details. Filing is by serial number and recognized nomenclatures are used. Cross-indexing according to disease is in arrears since about 1941, and cross-indexing according to operation has not been developed. It was stated that the cross-indexes, as far as developed, are little used by the medical staff for group studies or other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well-organized clinical and surgical pathological laboratories, in which all types of laboratory procedures are carried out. The part-time pathologist, Dr. E. W. Rapp, is qualified by training and experience, and spends approximately half time in the department. He is assisted by four full-time, trained technicians, of whom three are registered. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well quipped with radiographic and fluoroscopic apparatus. The pathologist, Dr. E. W. Rapp, also acts as roentgenologist and spends half of each day in the department. His qualifications as roentgenologist consist of training and experience. Two full-time, trained technicians are employed.

The facilities for physical therapy in the hospital are fairly complete and are supervised by the pathologist-radiologist. Two full-time, trained technicians are employed and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of two major and one minor operating rooms for general surgery and one major room for ophthalmology-otolaryngology, sterilizing, and workrooms. The various workrooms seem to be situated for the greatest convenience and are said to be adequate in extent for the present size of the hospital. The supply of surgical instruments is extensive and is probably sufficient in number and variety for any operation ordinarily performed in the hospital. Two graduate nurses and two orderlies are assigned to the department.

The full-time general surgical staff consists of three members, supervised by the chief of surgery. The general and orthopedic surgery is done by members of



this group without specialization, while all urological surgery is done by the consultant in urology. A majority of the operations in ophthalmology-otolaryngology are performed by a member of the consulting staff, while the one full-time staff member assigned to that work does the lesser portion of such surgery.

The chief of surgery is responsible, through the manager and clinical director, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are, limitation of privileges, routine examination of tissues removed, the closed-staff organization, and complete preoperative recording.

Anesthetics in the department are administered entirely by members of the surgical staff, supervised by the chief of surgery, Dr. R. H. Foster. The usual types of anesthesia are used, including pentothal sodium; nitrous oxide is not used, however. Special records are not made of anesthetics administered. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

Any infections occurring postoperatively in clean surgical cases are recorded in the office of the chief of surgery. In the event that a postoperative infection occurs, the incident is exhaustively investigated, the source of infection determined if possible, and corrective measures taken.

During the year 1943 there were 252 major and 533 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Veteran patients are admitted in all general branches of medicine and surgery; few female patients are treated, however, although eligible for admission. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. Beds have not been allotted for patients in the various divisions of general and specialized surgery. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During the year 1943 the average daily census of the hospital was 334, and 4,077 patients were admitted. A division of admissions into clinical services is not available due to the fact that patients come in through the reception out-patient department to the diagnostic service and are thoroughly worked up before the diagnosis is announced. The nearest possible approximation of the number of surgical patients admitted is said to be the number of operations performed, which is 252 major and 533 minor.

In the out-patient department during 1943, for purely out-patient purposes, 123 patients were given 688 treatments, and 3,277 patients were admitted for a total of 6,566 examinations, the latter probably chiefly for rating purposes.

Autopsies during 1943 were 22/239, or 9 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—An obstetrical service is not maintained in the hospital.

*Out-patient department.*—A member of the full-time medical staff is in charge of the out-patient and reception service, assisted by one member of the full-time medical staff. Patients are admitted in the usual out-patient sense for diagnosis and treatment and for rating purposes, practically all hours of the day, except Sunday, there being no set clinic hours for patients in the various surgical classifications. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are made and filed in the department. The appointment system is used as a means of follow-up of patients.

*Pharmacy.*—The hospital is supervised by a full-time, registered pharmacist. Only pharmaceutical preparations of standard quality are used. Complete records are maintained of drug stock and narcotic supplies and records are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 48 graduate nurses on duty at the time of survey, 12 of

whom were in supervisory capacity and 36 on general duty, allowing a nurse-patient ratio of about 1 to 7. Conferences of the entire nursing staff are held weekly throughout the year for the consideration of administrative and other matters. The nurses occupy a home which is of modern, fireproof construction.

There are, in addition to the graduate nurses, 74 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—The hospital has an organized dietary department. Three dietitians are employed, two of whom are graduates of approved schools of dietetics and members of the American Dietetic Association. The third member of the group is an older graduate and is said to be here "on trial"; is said not to be a qualified dietitian. Members of the departmental group are active in consultation with the staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical special service department.*—The hospital does not maintain a department of medical social service.

*Library.*—The medical library of the hospital contains 331 current, standard texts, and receives 20 medical periodicals monthly. A full-time librarian is in charge of the medical library.

*Residencies.*—Plans have not been drawn up for graduate training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—The Veterans' Administration hospital in Memphis appears to have some possibilities as a center for graduate training in general surgery. The quantity of clinical material in admissions to the hospital would seem to justify the establishment of a program of training, but the clinical material in the outpatient department is negligible and the volume of surgery done is rather less than necessary to afford good training to a surgical resident. The conclusion seems to be justified, therefore, that the institution could not undertake the training of a surgical resident through a program of 4 years, although it might well have a part in the over-all program in veterans' hospitals by giving training of 1 or 2 years' duration. The surgical staff seems to be well organized and members of the group expressed interest in the subject of graduate training in surgery. The consultant in urological surgery is a fellow of the American College of Surgeons, but no other member of the full-time surgical or consulting group holds fellowship in the college.

Among the points of importance to be considered if a graduate training program in general surgery is established in this hospital are: the holding of clinicopathological conferences, and surgical departmental meetings if the size of the surgical staff seems to justify them, to insure adequate review of the clinical work and experience and instruction for the residents; bringing the cross-indexing of medical records according to disease up to date and development of cross-indexing according to operation; the autopsy percentage, which, according to the recommendation of the American College of Surgeons, should be at least 50 percent if graduate training in surgery is to be undertaken in the hospital. The foregoing points, as well as the fact that special records are not made of anesthetics administered, are likewise of importance in the field of hospital standardization.

PAUL S. FREDERSON, M. D.,  
Director of Surveys.

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VETERANS' ADMINISTRATION HOSPITAL, KECOUGHTAN, VA.

(Lt. Col. John E. Kelly, chief medical officer; Col. Keith Ryan, manager)

MAY 19, 1945.

*General.*—This is a general hospital with an official bed capacity of 538. The physical plant consists of a four- to six-story and basement, modern, fireproof building. The equipment in all departments appears to be adequate for efficient diagnosis and treatment and is of good quality.

The hospital is administered by a manager who is a layman, assisted by the chief medical officer and a clinical director. Members of the medical staff are on United States civil service status and are assigned to this hospital by the



Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 15 active and 3 Dental Corps members is organized on the closed plan, the chief medical officer acting as chief of staff, assisted by the clinical director. There is basic departmentalization with departmental heads who are active in control of the clinical work. The one consultant is a specialist in urology from a nearby locality, who is on part-time, salary basis and visits the hospital twice weekly.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. Programs consist of the consideration of patients admitted, diagnoses and treatment, clinical cases in general, deaths for general review, and rarely administrative matters. Clinicopathological conferences are held weekly throughout the year. These meetings appear to afford an adequate review of the clinical material and are regularly attended by the pathologist-radiologist. Minutes and attendance records of the general staff meetings are kept. Departmental meetings are not held on account of the small size of the medical staff.

There are at present no interns or residents on duty in the hospital.

*Medical records.*—A full-time, trained librarian has charge of the completed medical records, assisted by a large corps of trained clerks. The records are prepared by the staff medical officers and appear to be complete in all essential details. Filing is by serial number, recognized nomenclatures are used, and cross-indexing according to disease and operation is up to date. The cross-indexes are used to some extent by the medical staff for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well-organized clinical and surgical pathological laboratories, in which all usual types of laboratory procedures are carried out; some of the more unusual serological tests are carried out for this laboratory by the department in the San Francisco and Hines Veterans' Hospitals, however. The part-time pathologist, Dr. B. Miller, is qualified by training and experience, and spends about half-time in this department. He is assisted by three full-time, trained technicians, two of whom are registered. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The pathologist, Dr. B. Miller, also acts as roentgenologist and spends approximately half-time in the department. He is qualified for roentgenology by training and experience. Two full-time, trained technicians are employed.

The facilities for physical therapy in the hospital are fairly complete and are supervised by the pathologist-radiologist. Two full-time, trained technicians are employed, of whom one is registered, and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of one major and one minor general operating rooms, a fracture room, one major room for ophthalmology-otolaryngology, a cystoscopic room in the roentgenological department, sterilizing and work rooms. The various rooms are situated to good advantage and are said by the surgeons to be adequate in extent for the present size of the hospital. The supply of surgical instruments appears to be sufficient in number and variety for any type of operation ordinarily performed in the hospital. Two graduate nurses and one orderly are assigned to the department.

The full-time surgical staff consists of five members, supervised by the chief of surgery. The general surgery, and all specialized surgery with the exception of ophthalmology-otolaryngology, is done by the chief of department and three assistants without much specialization, while the surgery in ophthalmology-otolaryngology is done by the specialist in that work who is the fifth member of the surgical group. It appears that the services of the consulting urologist are not utilized as far as the performance of surgical operations is concerned.

The chief of surgery is responsible, through the manager and chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and specialty divisions necessarily share in his responsibility, however. Additional means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.



Anesthetics in the department are administered entirely by members of the surgical staff, supervised by the chief of surgery, Dr. E. S. Roberts. The usual types of anesthesia are used, including pentothal sodium; special records of anesthetics administered are not made. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

A record of any infections occurring postoperatively in clean surgical cases is maintained in the office of the chief of surgery. In the event that such an infection occurs, the circumstances are carefully investigated, the source of infection determined if possible, and corrective measures taken.

During the year 1943 there were 208 major and 827 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general and specialized surgery, were not available for review. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery, but few female patients are admitted, although certain classifications of them are eligible for hospitalization. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. The following beds are reserved for surgical patients—105 in general surgery, 45 for orthopedic surgery and fractures, 28 for urological surgery, and 18 for ophthalmology-otolaryngology. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 299, and 2,226 patients were admitted. A division of patients admitted into clinical services is not available due to the fact that admissions are through the reception out-patient department to the diagnostic service and cases are thoroughly worked up before the diagnosis is announced. The nearest possible approximation of the number of surgical patients admitted is the number of operations performed, which is 208 major and 827 minor.

In the out-patient department during 1943, for purely out-patient purposes, 8,655 patients were given 22,242 treatments, and 8,004 patients had 8,063 examinations, the latter probably, chiefly, for rating purposes. It is to be noted that inmates of the nearby domiciliary home receive out-patient care in the hospital although few of them are hospitalized.

Autopsies during 1943 were 97/177, or 55 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—The hospital does not maintain an obstetrical service.

*Out-patient department.*—The out patient and reception service is staffed by two members of the full-time medical staff. Patients are admitted in the usual out-patient sense for diagnosis and treatment, and for rating purposes, from 8:30 a. m. until 4 p. m. 5 days in the week and from 8:30 a. m. until 11 a. m. on the sixth day of the week. Complete records of patient visits, physical findings, and treatment administered, as well as the physical findings for rating purposes, are made and are on file in the department. The appointment system is utilized as a means of follow-up on patients.

*Pharmacy.*—The hospital pharmacy is supervised by a full-time, registered pharmacist. All pharmaceutical preparations used are of standard quality. Complete records are maintained of drug stock and prescriptions, and narcotic supplies and records are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 37 graduate nurses on duty at the time of survey, 11 of whom were in supervisory capacity and 26 on general duty, allowing a nurse-patient ratio of about 1 to 8. Conferences of the entire nursing staff are held regularly every 2 weeks for the consideration of administrative and other matters. The nurses occupy a modern, fireproof home.

There are, in addition to the graduate nurses, 68 subsidiary workers on duty who are active in the care of patients in the hospital.

*Dietary department.*—Two dietitians are employed in the organized dietary department of the hospital. The assistant is a graduate of an approved school and a member of the American Dietetic Association. Members of this staff are active

in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—One full-time, trained worker is employed in the department of medical social service. Investigations are made of social conditions among patients, and to some extent, of financial conditions. Full reports of these investigations are on file in the patients' medical records and in the department. The department follows up discharged patients through the media of mail and telephone, and in some instances by home visits.

*Library.*—The hospital has a medical library of 305 volumes, of which 38 are current, standard texts, and 22 medical periodicals are received monthly. A full-time librarian is in charge of the medical library.

*Residencies.*—Plans have not been drawn up for graduate training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—It is improbable that the quantity of clinical material in admissions to the hospital and the out-patient department and the volume of surgery done will enable this hospital to carry a surgical resident through a full 4-year program and at the same time give him adequate training in general surgery. The hospital should be considered as eligible to take part in the over-all veteran hospital program, however, as being eligible to furnish training in 1 or 2 years of residency. The surgical staff is well organized and the members of that group appear to be well informed and interested in their work. They expressed considerable interest in the subject of graduate training in surgery. The chief of surgery is a fellow of the American College of Surgeons.

Among the points that should have consideration if a graduate training program is to be established in this hospital is the supervision of the clinical laboratory and the roentgenological departments by full-time, qualified physician specialists. Of importance in the field of hospital standardization, in addition to the foregoing, are the lack of a graduate dietitian in charge of the dietary department, the slightly high ratio of graduate nurses to patients, and the fact that special records are not made of anesthetics administered in the surgical department.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*

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#### VETERANS' ADMINISTRATION HOSPITAL, WOOD, WIS.

(Dr. Glenn Mullins, chief medical officer; Mr. P. G. Froemming, manager)

JANUARY 31, 1944.

*General.*—This is a general hospital with an official bed capacity of 1,168. The physical plant consists of two buildings, of two stories and basement, modern, fireproof construction. At the time of survey it was stated that, due to alterations in the physical plant, such as enclosing sun porches, 167 beds had been added to the capacity for tuberculosis patients and would be put into use as soon as medical officers to staff them were available. It was expected that 70 more beds for tuberculosis patients, in addition to the 167, would be available within the next 2 to 3 months following the date of survey. These additional beds are not included in the official capacity of the hospital stated above. The equipment in all departments of the institution appears adequate for efficient diagnosis and treatment, and is of good quality.

The hospital is administered by a manager, who is a layman, assisted by the chief medical officer and a clinical director. Members of the medical staff are on United States Civil Service status and are assigned to this hospital by the Medical Director of the Veterans' Administration. The medical staff functions under Federal regulations.

*Medical staff.*—The full-time medical staff of 34 active members is organized on the closed plan, the chief medical officer acting as chief of staff, assisted by the clinical director. There is fairly extensive departmentalization with heads of departments and subdivisions who are active in control of clinical work. The consulting staff of seven members comprises an outstanding group of local medical and surgical specialists, some of whom are said to be on the faculty of the medical school of Marquette University in Milwaukee. Some members of the con-



sulting group are on part-time salary basis and visit the hospital regularly, while others are on fee basis and are called as the need arises.

The medical staff meets regularly each week throughout the year for a review of the clinical work of the hospital. The program consists of consideration of diagnoses, clinical cases in general, deaths and autopsy material, and sometimes administrative business. Departmental meetings are held in medicine, surgery, tuberculosis, and neuropsychiatry at irregular intervals. These meetings appear to afford a fairly adequate review of the clinical work and are regularly attended by the pathologist and radiologist. Minutes and attendance records of the general staff meetings are kept. Clinicopathological conferences are not held.

There are no residents or interns on duty in the hospital at this time.

*Medical records.*—A full-time, trained librarian has charge of the completed medical records, assisted by a large corps of trained clerks. The records are prepared by the staff officers and appear to be complete in all essential details. Filing is by serial number, a recognized nomenclature is used, and cross-indexing according to disease is up to date. The cross-indexes are used by the medical staff to some extent for group studies and other research purposes.

*Diagnostic and adjunct facilities.*—The hospital has fully equipped and well-organized clinical and surgical pathological laboratories in which all types of laboratory procedures are carried out. The space allotted to this department was, at the time of survey, entirely inadequate to carry out efficient work despite previous recommendations of the American College of Surgeons that the department be enlarged. Plans of rather indefinite and nebulous nature for enlarging the department were mentioned at the time of survey. The consulting pathologist, Dr. B. H. Schlomvitz, is qualified by training and experience and spends an average of 4 hours daily in the department. He is assisted by seven full-time, trained technicians, of whom one is registered. All tissues removed at operation are examined and full reports rendered.

The roentgenological department is well equipped with radiographic and fluoroscopic apparatus. The full-time roentgenologist, Dr. A. R. Shirley, is qualified by training and experience. Three full-time, registered technicians, of whom one is registered, are employed.

The facilities for physiotherapy in the hospital are complete and are supervised by Dr. E. L. Artman, the staff orthopedist. Six full-time, trained technicians are employed, of whom two are registered, and complete records of treatments are maintained in the department.

Other adjunct facilities are basal metabolic and electrocardiographic apparatus, and occupational therapy, all of which are competently supervised.

*Surgical department.*—The facilities for surgery consist of three major operating rooms, a cystoscopic room in the roentgenological department, one major room for ophthalmology-otolaryngology, sterilizing, and workrooms. The various rooms are situated for the greatest convenience and are said by the surgical staff to be adequate in extent for the present needs of the hospital. The supply of surgical instruments is extensive and appears to be sufficient in number and variety for any type of operation ordinarily performed in the hospital. Three graduate nurses and two orderlies are assigned to the department.

The full-time surgical staff consists of six members supervised by the chief of surgery. General surgical operations are performed by the chief of department and two assistants; there is some degree of specialization, however, for orthopedic and urological surgery and proctology. The staff ophthalmologist-otolaryngologist and one assistant do a majority of the surgery in that combined specialty. The services of the consultants are freely used in performing operations of more difficult nature in general surgery, orthopedic and urological surgery, ophthalmology-otolaryngology, and plastic surgery.

The chief of surgery and the ophthalmologist-otolaryngologist are responsible through the manager and the chief medical officer, to the Medical Director of the Veterans' Administration for all surgery done in the hospital; other members of the general surgical and the specialty divisions necessarily share in their responsibility, however. Additional means for the control of surgery are limitation of privileges, routine examination of tissues removed, the closed staff organization, and complete preoperative recording.

Anesthetics in the department are administered by members of the surgical staff, supervised by the chief of surgery, Dr. J. G. Slaney. The usual types of anesthesia are used, including pentothal sodium; special records are not made



of anesthetics administered. Full recording of the physical examination, diagnostic laboratory procedures, and the provisional diagnosis is required before the administration of an anesthetic may begin.

Any infections occurring postoperatively in clean surgical cases are recorded in the office of the chief of surgery. In the event that a postoperative infection occurs, the circumstances are carefully investigated, an effort made to trace the infection to its source, and corrective measures taken.

During the year 1943 there were 704 major and 756 minor operations performed in the hospital. Records as to the nature of these operations, collectively, or their division into general or specialized surgery, were not available. Since there are no residents in the hospital, a statement as to how many operations will be performed by a resident in any year cannot be made. In the past, however, younger surgeons on a status comparable to residents have done a limited volume of major and minor surgery under supervision. This arrangement will continue until such time as residencies may be established in the hospital, although the younger surgeons will be advanced in responsibility in surgery as ability is demonstrated.

*Clinical material.*—Male veteran patients are admitted in all general branches of medicine and surgery; few female veteran patients are admitted, although they are eligible for treatment. Patients with communicable diseases are not admitted as a general policy, but ample means for segregation and isolation make possible the care of such patients when the need arises. The number of beds allotted to the various classes of surgical patients could not be ascertained. Patients are not classified as either free or paying, but all are available and may be utilized for teaching purposes.

During 1943 the average daily census in the hospital was 872, and 3,859 patients were admitted. A division of patients admitted into clinical services is not available, due to the fact that admissions are through the reception out-patient department to the diagnostic service, and each case is thoroughly worked up before the diagnosis is announced. The nearest possible approximation of surgical patients among the admissions is said to be the number of operations performed, which is 704 major and 756 minor. One hundred and twenty-two acute fractures were admitted for treatment during the year and 19 open reductions were performed among them, with 1 postoperative infection.

In the out-patient department during 1943, for purely out-patient purposes, 12,515 individuals were given 55,981 treatments, and 11,608 patients were subjected to a total of 32,473 examinations, the latter probably chiefly for rating purposes. Residents in the nearby domiciliary home are eligible for treatment examination in the department.

Autopsies during 1943 were 97/307, or 31 percent. Complete protocols are on file in the surgical pathological laboratory for all autopsies performed.

*Obstetrics.*—The hospital does not maintain an obstetrical service.

*Out-patient department.*—The out-patient reception department is staffed by a group of full-time officers, supervised by the chief of service. Patients are admitted in the usual out-patient sense, for diagnosis and treatment, and for rating purposes, from about 8 a. m. until 4:30 p. m., daily except Sunday. Complete records of patient visits, physical findings, and treatments administered, as well as the physical findings for rating purposes, are on file in the department. The appointment system is used as a means of follow-up on patients.

*Pharmacy.*—The hospital pharmacy is supervised by a full-time registered pharmacist. All pharmaceutical preparations used are of standard quality. Complete records are maintained of drug stock and prescriptions, and narcotic records and supplies are checked regularly.

*Nursing.*—The nursing staff is supervised by a full-time directress of nursing. There was a staff of 121 graduate nurses on duty at the time of survey, 24 of whom were in supervisory capacity and 97 on general duty, allowing a nurse-patient ratio of about 1 to 7½. Conferences of the entire nursing staff are held twice monthly for the consideration of administrative and other matters. The nurses occupy a home which is of part fireproof, part nonfireproof construction.

There are, in addition to the graduate nurses, 199 subsidiary workers on duty who are active in the care of patients in the hospital.

As noted elsewhere in this résumé, 167 beds have recently been added to the capacity of the institution and 70 more were to be added within the very near future. The beds available had not been put into use at the time of survey on account of a shortage of staff medical officers, and to some degree a shortage of nurses.

*Dietary department.*—Five dietitians are employed in the organized dietary department of the hospital, all of whom are graduates of approved schools and members of the American Dietetic Association. Members of the department are active in consultation with staff physicians in the planning and preparation of special diets for patients, whose medical records are always available for examination in connection with that purpose. The hospital kitchen, refrigerators, preparation, and supply rooms were visited and found to be in sanitary condition.

*Medical social service department.*—The department of medical social service employs two full-time, trained investigators. Inquiries as to social conditions among patients are made when indicated and full reports of these investigations are on file in the patients' medical records. Follow-up work is carried on chiefly among discharged neuropsychiatric patients, through the media of mail and telephone, and to some extent, by home visits.

*Library.*—The medical library of the hospital contains 407 current, standard texts, and 21 medical periodicals are received monthly. A full-time librarian is in charge of the library.

*Residencies.*—Plans have not been drawn up for graduate training programs in general surgery or the surgical specialties. An affiliation with a medical school for any educational purpose or for the granting of higher medical degrees has not been established.

*Conclusions.*—This unit of the Veterans' Administration appears to have sufficient clinical material in admissions to the hospital and out-patient department to justify the establishment of a residency in general surgery, and the volume of surgery done is adequate for that purpose. The administrative, medical, and surgical staffs are well organized for the instruction of residents and the supervision of their work in the operating rooms and on the wards. All members of the foregoing groups who are interviewed during the visit to the institution expressed keen interest in the subject of graduate training and would welcome the opportunity to instruct and develop residents in a 4-year program of graduate training in surgery. The chief of surgery and the consultants in orthopedics and ophthalmology-otolaryngology are fellows of the American College of Surgeons.

Among the points of importance to be carefully considered in the event that a graduate training program is established in this hospital are, the holding of surgical departmental meetings and clinicopathological conferences at regular and frequent intervals; cross-indexing of the medical records according to operation; the supervision of the clinical laboratory and roentgenological departments by full-time, qualified physicians; the allotting of sufficient space to the clinical laboratory to enable that department to carry on prompt and efficient service; the autopsy record. It is recommended by the American College of Surgeons that in hospitals where graduate training programs are functioning or are contemplated, the autopsy percentage be at least 50 percent and as much more as possible. Of importance in the field of hospital standardization, in addition to the foregoing, is the nurse-patient ratio.

PAUL S. FERGUSON, M. D.,  
*Director of Surveys.*





# INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY OF THE ADMINISTRATION AND OPERA- TION OF VETERANS' ADMINISTRATION FACILITIES

WEDNESDAY, JUNE 27, 1945

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WORLD WAR VETERANS' LEGISLATION,  
*Washington, D. C.*

(The committee met at 10 a. m., Hon. James Domengeaux presiding, for further consideration of H. R. 3310.)

Mr. DOMENGEAUX. The committee will come to order.

Mr. McQUEEN, do you have a witness?

Mr. McQUEEN. Yes; Dr. Adams.

Dr. GRIFFITH. Mr. Chairman, may I introduce Dr. Roy D. Adams, Washington, D. C., clinical professor of medicine of Georgetown University School of Medicine, and one of our consultants on the advisory board.

Mr. DOMENGEAUX. Yes.

Dr. GRIFFITH. Dr. Adams.

## STATEMENT OF DR. ROY D. ADAMS, WASHINGTON, D. C., CLINICAL PROFESSOR OF MEDICINE OF GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE AND VISITING PHYSICIAN IN INTERNAL MEDI- CINE, COLUMBIA HOSPITAL

Mr. DOMENGEAUX. Doctor, I understand that you have some testimony to give and a report to make to this committee which we will be glad to receive.

Mr. McQUEEN. Now, first, Doctor, state your full name for the record.

Dr. ADAMS. Roy D. Adams.

Mr. McQUEEN. Doctor, what schools are you a graduate of?

Dr. ADAMS. Georgetown University, sir.

Mr. McQUEEN. And your premedical education?

Dr. ADAMS. High school.

Mr. DOMENGEAUX. Mr. McQueen, a little louder, please.

Mr. McQUEEN. Yes.

Dr. ADAMS. High school.

Mr. McQUEEN. High school?

Dr. ADAMS. Yes, sir.

Mr. McQUEEN. You are a practicing physician here in Washington?

Dr. ADAMS Yes, sir.

Mr. McQUEEN. And on the advisory board for the Veterans' Administration?

Dr. ADAMS. Yes, sir.

Mr. DOMENGEAUX. I think this would clarify it to the committee, exactly what are the duties of the members of the advisory board, Doctor?

Dr. ADAMS. The chief duties of the advisory board are to take up questions which are asked by the medical service or the Administrator of Veterans' Affairs of members of that board, and at the same time in the performance of those duties, where deficiencies or recommendations occur to the advisory board, to make such recommendations to the Administrator of Veterans' Affairs.

Mr. DOMENGEAUX. These members are appointed by the Administrator of the Veterans' Administration?

Dr. ADAMS. Yes, sir.

Mr. DOMENGEAUX. Are they appointed for any definite period of time, and what compensation is received by the members?

Dr. ADAMS. There is no definite time for which they are appointed. They meet at irregular intervals. The compensation is \$20 a day plus traveling expenses.

Mr. DOMENGEAUX. Thank you, Doctor.

Dr. ADAMS. During the time of meeting, from the time they leave their homes to the time that they return.

Mr. DOMENGEAUX. Proceed, please, Doctor.

Mr. McQUEEN. Now, Doctor, you have a statement and some recommendations that you have discussed in your meeting here, and we would be glad to hear you.

Dr. ADAMS. I have very few points to bring out. The subject has already been very thoroughly covered, particularly so far as the crystallized opinion of the medical council after many meetings in regard to some of the salient points in connection with the medical service of the Veterans' Administration is concerned. I might say that the opinions expressed by Dr. Piersol in the opening testimony before this committee, by the group of which I am a member, covered, without going into detail, the salient and important points that have come up at the many meetings, and to attempt to add much to what Dr. Piersol had to say would be to subtract from it.

Mr. McQUEEN. What is your specialty, Doctor?

Dr. ADAMS. Internal medicine, sir.

Mr. McQUEEN. Can you give the committee any suggestions that might be of benefit to them and for their use in the hospital set-up of the Veterans' Administration pertaining to your specialty now?

Dr. ADAMS. What I would have to say about my specialty would obtain so far as any of the specialties are concerned. If you would care to I would be glad to emphasize a few of the essentials, so far as that is concerned.

Mr. McQUEEN. I would be glad if you would, Doctor.

Dr. ADAMS. In the first place the establishment of a medical service with a recognized standard and with a corps selected in such a fashion as to obtain the best possible medical talent, particularly, so far as young men are concerned with a power to act in medical matters, so that those young men and the older ones, for that matter,

have not only the opportunity, but the necessity of keeping up with modern medicine through courses in the Veterans' Administration hospitals which are properly located and staffed to give such courses, and especially the privilege of attending courses in universities where courses are presenting things which are needed particularly by the individual in his chosen work, and that such organization must have the dignity of the Public Health Service, the Army or the Navy Medical Corps, that so far as the functioning of those members are concerned, regardless of what kind of an organization is ultimately decided on, the emphasis should be placed on the physician and not the physician's rank.

Mr. McQUEEN. Not the physician's what?

Dr. ADAMS. Rank.

Mr. McQUEEN. Rank?

Dr. ADAMS. Yes. That is, that the medical corps or medical service of the Veterans' Administration should be made up of doctors, not of colonels or captains or lieutenant colonels, or what you will, that such rank might well be possessed by those members, but in the last analysis the functions of the members of the Veterans' Administration medical service should be first as doctors, and should be so thought of by the patients in the hospitals.

Mr. McQUEEN. Right along that line, Doctor, would you recommend as soon as possible that the Veterans' Administration go back to the system which it had without rank and title of the Army, but be referred to as doctors throughout the service by patients, and otherwise?

Dr. ADAMS. As soon as the present emergency is over. There is good reason why the men in the service at the present time should be in uniform and have rank. They would have a difficult time in civilian clothes, many of them, the younger and most useful men explaining their citizens' clothes if they were not in uniform. However, when the present emergency is over, I think the trend should be as quickly as possible to return to a medical status for the men in the Administration practicing medicine rather than to maintain a uniform and the formality of Army or Navy rank.

Mr. McQUEEN. Doctor, you spoke of a training for these medical men for the service comparable to the Public Health Service. Are you in favor of a medical center being established here for that purpose, is that your idea?

Dr. ADAMS. There would be certain advantages and possibly some disadvantages in a training center established here. The Army, the Navy, and the Public Health Service having large medical centers here would indicate an appropriate similar center by the veterans center maintained by the Veterans' Administration. However, so far as centralized teaching facilities in Washington or in any other place are concerned, I think such a course would be a mistake. I think that teaching should be done where teaching may best be furnished, where there are the best medical faculties in relation to big universities, and where adequate clinical material is available by the hospitals in the Veterans' Administration, that that would be the appropriate place for teaching.

Mr. McQUEEN. In other words, you mean that any special or any branch of medicine should not be centralized in one place, it should



cover the whole country and the facilities that have been used for this teaching?

Dr. ADAMS. I think any other course would be a mistake.

Mr. McQUEEN. What are your ideas in regard to the medical staff of the Veterans' Administration, as to the administration of that staff; what would you suggest for the benefit of the committee on that?

Dr. ADAMS. I think the essentials are very well suggested and very well portrayed in H. R. 3310.

Mr. McQUEEN. Do you feel that doctors selected through civil service hinder the Veterans' Administration in giving proper medical care to the patients of these hospitals?

Dr. ADAMS. I do, sir, and have always felt that way.

Mr. McQUEEN. What would be your recommendations or suggestions to the committee in regard to the staffing of these hospitals and the management of the hospitals throughout the country? Should they be under the direct supervision of medical men, or should there be managers of the hospitals with the clinical staff separate?

Dr. ADAMS. I think they should be under doctors. In that connection I think there should be, where medicine is practiced, no Veterans' Administration facilities, but Veterans' Administration hospitals.

Mr. McQUEEN. In other words, you would suggest that the Claims Department and the regional office be entirely divorced from the hospital itself?

Dr. ADAMS. Yes, sir.

Mr. McQUEEN. And kept that way?

Dr. ADAMS. Yes, sir.

Mr. DOMENGEAUX. Doctor, how long have you been a member of this Advisory Board?

Dr. ADAMS. Since its first meeting, sir; in 1924.

Mr. DOMENGEAUX. Why is it that you and the other members who preceded you, who are members of this Advisory Board, should wait some 20 years before making your recommendations to the Administrator, as so many of those have been offered which are revolutionary and which could not have been evolved overnight. Why is it that such a long time was allowed to elapse before recommendations were made to the Administrator?

Dr. ADAMS. I am not sure as to what just recommendations you refer to.

Mr. DOMENGEAUX. Generally speaking.

Dr. ADAMS. May I read a resolution passed by the—

Mr. DOMENGEAUX (interposing). Pardon me. If they were made, do you know why they were not accepted and put into effect by the Administrator?

Dr. ADAMS. Sir, I think the answer to that question can come from some other source more reliably than from me.

Mr. DOMENGEAUX. Yes, sir.

Dr. ADAMS. But in answer to your question I would like to read this particular resolution which was passed at the eighth conference of the Medical Council in April 1928.

Mr. DOMENGEAUX. Yes, sir.

Dr. ADAMS (reading):

Whereas at the first meeting of the Medical Council of the United States Veterans' Bureau, after due deliberation, the council went on record that "the only

way in which the highest grade of medical service can be offered to the ex-service-men who are referred to the Bureau for care, is by having an independent medical corps, similar to the organization of the United States Public Health Service, or the Medical Corps of the United States Army or Navy"; and

Whereas the council, at its meeting November 1924, submitted the text for a bill to create a permanent medical service in the United States Veterans' Bureau, and

Whereas at every successive meeting of the Medical Council the council has gone on record as favoring the creation of such a permanent medical service, and

Whereas at the present time the committee in charge of veterans' legislation of Congress has before it for consideration, a bill, H. R. 12627, which provides for the establishment of a commissioned medical service in the United States Veterans' Bureau, and is now holding hearings on that bill: be it

*Resolved by the Medical Council of the United States Veterans' Bureau, in stated meeting assembled.* That it is the unanimous opinion of its members that in order to assure proper care of the wards of the Government, which, under the laws of Congress the Veterans' Bureau is obligated to provide, it is necessary to attract and to retain in that service physicians and surgeons who are thoroughly competent to render the highest type of medical service; and that, in order to accomplish this, a career of dignity and stability must be provided similar to that of the Medical Corps of the Army, the Navy, and the Public Health Service; and that the only way in which this can be accomplished is by the creation of a medical corps in the Veterans' Bureau such as is provided in the bill now under consideration; and be it further

*Resolved.* That the Director of the Veterans' Bureau be requested to transmit a copy of this resolution to the respective chairmen of the Committees on Veterans' Legislation of the Senate and House of Representatives, with the least practicable delay.

Mr. DOMENGEAUX. Well, now, if I understand, since 1928—

Dr. ADAMS (interposing). Since 1924.

Mr. DOMENGEAUX. Since 1924 this advisory board composed of outstanding doctors throughout the country has repeatedly recommended that the only way in which the most desirable doctors could be secured and adequate medical service given was by the establishment of such a board, and that has been recommended to the Administrator year after year, is that correct?

Dr. ADAMS. That is correct, sir, at every meeting of the council.

Mr. DOMENGEAUX. And nothing has been done about that until the introduction of H. R. 3310?

Mr. MATHES. I think there have been several bills introduced on that through the years, but I do not know.

Mr. DOMENGEAUX. But always opposed by the Veterans' Administration?

Mr. MATHES. I do not happen to know from memory. What was done as to each of those bills, I do not know.

Mr. DOMENGEAUX. But is it not true that each bill that was introduced, including Mrs. Rogers' bill was opposed by the Veterans' Administration?

Mr. MATHES. I do not know the answer to that, but if you want to know I can find out this afternoon for you.

Mr. DOMENGEAUX. The fact remains that nothing has been done since 1924 when these recommendations were made by this outstanding advisory board?

Mr. MATHES. There has been no enacted legislation. What was done short of that I do not happen to know.

Mr. DOMENGEAUX. Whether Congress is responsible for that or the Administrator, it is up to the public to determine.

Mr. MATHES. I do not know about that.

Dr. ADAMS. May I state that many of the proceedings of the council have been on matters which scarcely justified busy and exceedingly active medical members assembling from over the United States unless the medical center in the Veterans' Administration was such as to make it possible to carry out recommendations of the council on various branches of medicine and procedure in hospitals. I would like to state, however, that in spite of the absence of any adequate method of selecting and continuously training medical personnel, it has done a superb job under the circumstances.

Mr. DOMENGEAUX. Oh, I think so. Doctor, did this advisory board periodically inspect hospitals at their own discretion, or what was the method of procedure?

Dr. ADAMS. A number of the members of the council were living in cities close to Veterans' Administration hospitals. Some of them were acting as consultants, as I have, to a nearby hospital. A number of them made, at the request of the Medical Director, or the Administrator, visits of inspection to hospitals at various times. There was no organized inspection of hospitals at any time by the various members of the group.

Mr. DOMENGEAUX. Therefore, as to the advisory board, their individual conclusions were derived by the opportunity that they had to observe when they were there in a consulting capacity attending to various patients, is that correct?

Dr. ADAMS. That is correct. There were, however, a number of special visits to hospitals by members of the board at the request of the Administrator or the Medical Director, but those were in no systematized fashion, but under certain circumstances.

Mr. DOMENGEAUX. Well, did this advisory board ever make officially, by action of the board, complete surveys to determine the methods of management, the type of service and the medical care given to the patients, and generally that which entailed the required efforts to make an adequate survey of a system of this size?

Dr. ADAMS. The board of advisers never in any such organized fashion as you suggest surveyed the hospitals. When they did make visits to those hospitals it was chiefly in relation to the medical care of patients there. However, the medical board was kept informed as to the status of the hospitals through a member of the group, Dr. MacEachern, who has, for many years, and who you heard yesterday, been the most active in the periodical survey of hospitals in the country generally, not only of veterans' hospitals.

May I say that the inspection of hospitals by the American College of Surgeons is the most extensive and exhaustive and extended survey which is made of hospitals in this country at the present time.

Mr. DOMENGEAUX. Now, Doctor, as an illustration, did you or any member of the board, or the board officially, ever make a study of the paper work and the routine office work that was required of each doctor connected with the facility to determine whether this work was of such a nature that it took away from this doctor an opportunity to render adequate and efficient medical service?

Dr. ADAMS. A number of members of the group inspecting hospitals went into the subjects which you mention and the opinion was always that there was a tremendous amount of added duties which prevented the medical officer from giving as much of his time as is desirable to patients.



Mr. DOMENGEAUX. Doctor, this may be an embarrassing question to one of your profession, and pardon me if I overstep the bounds, but would you voice an opinion as to the mental aptitude and professional attainment of the average doctor connected with the veterans' facility in comparison to doctors in private hospitals and in private practice? Do they come up to standard, in other words?

Dr. ADAMS. I would say that the average is as good, that there are a number of men serving in veterans' hospitals whom I would not like to have if I had charge of a hospital, but that obtains in most any hospital. The general standard, I think, is as good as that met in the general run of hospitals, not as good as that in teaching institutions nor university hospitals, but for the general run of hospitals, I think the medical personnel is as good. However, there is serious difficulty in the selection of men for positions in the Veterans' Administration. Under the existing system a considerable proportion of undesirables are bound to be appointed, and are separated with considerable difficulty. I think that is such a criticism as can be leveled by any fair-minded body investigating the hospitals. I think it would indicate the desirability of appointment of men by examination other than the assembled examination by the Civil Service Commission and especially by personal contact with the individual by a board who examines that individual, by a procedure similar to the one employed by the Public Health Service.

Mr. DOMENGEAUX. Yes, sir, I think you are perfectly correct, Doctor, as far as I am concerned.

Now, Doctor, out of this existing policy, is it not true that the average doctor who comes into the veterans' facility, even though he had ambition when he came in, and a desire to keep up with his profession, that the existing system would have the result of somewhat taking away from him the ambition and the desire for study that a doctor in private practice or in a public institution would have, because the competitive spirit is taken away, and he is called upon largely to satisfy the central office?

Dr. ADAMS. I think in the main the answer to your question would have to be "Yes," that the present routine work, and by the present routine work I mean the work of the last 4 or 5 years, has not been of a character to attract an ambitious and intelligent young man. What can be done by offering facilities for teaching was well shown at the diagnostic clinic here in Washington when in 1935 and 1936 that hospital was designated as a diagnostic center, and we gathered together teachers from Hopkins and from the local medical schools here and had daily visits of four or five consultants. There was a very great demand on the part of men in the Veterans' Administration to be assigned to this hospital because they had an opportunity to learn something every day, and it was clinical medicine. When through the economy years there had to be a falling off, and there was a falling off of the visits of those consultants, the interest waned, but the morale has been maintained at a higher level there, I am told, than at most of the other veterans' hospitals.

Mr. DOMENGEAUX. Then, Doctor, is it most desirable on the part of Government authorities to make possible and available to the doctors of the veterans' facility an opportunity to keep current and posted and to advance in their profession?

Dr. ADAMS. It is essential, sir.

Mr. DOMENGEAUX. It is essential?

Dr. ADAMS. Yes, sir.

Mr. DOMENGEAUX. Doctor, what has been the policy of the central office in the last 24 years, or since its inception in regard to that? Has it been good, poor, bad, or indifferent?

Dr. ADAMS. Well, I think there could have been at times considerably more enthusiastic support of recommendations made by the advisory council with regard to postgraduate courses, teaching, and research work.

Mr. DOMENGEAUX. Doctor, has it not been more or less the policy that the central office did very little toward encouraging or assisting the average doctor to keep informed in his profession, and that, as a matter of fact, doctors who had been connected with the Administration for years and years have never taken a refresher course and have never taken postgraduate work notwithstanding the fact that they have requested it?

Dr. ADAMS. Certainly the general opinion has been that it has been exceedingly difficult to procure additional training such as you indicate.

Mr. DOMENGEAUX. Yes.

Dr. ADAMS. Yes, sir.

Mr. DOMENGEAUX. That is true.

Dr. ADAMS. The usual reason given for that has been the shortage of men, the shortage of medical personnel.

Mr. DOMENGEAUX. Has that been true since the last war?

Dr. ADAMS. At times I have not been in position to tabulate the actual figures and I have felt that that point was overstressed.

Mr. DOMENGEAUX. Yes.

Dr. ADAMS. We ran, while we were going as we desired to go at Mount Alto, almost continuous refresher courses where students were selected, and medical officers were selected from the veterans' hospitals to come there to take those courses. There was a great amount of interest in it.

Mr. DOMENGEAUX. I did not want to monopolize the questions, gentlemen. Do you have any questions?

Mr. RAYFIEL. Doctor, you stated a little while ago, in response to a question by the chairman, that the gentleman that testified yesterday, and, incidentally I did not attend yesterday's session, would visit the various hospitals and keep you posted as to conditions there, is that right?

Dr. ADAMS. The organization of which he is a mainspring does that, and has been doing it for many years.

Mr. RAYFIEL. Did he give to your advisory board a report of his findings at these various institutions?

Dr. ADAMS. Yes, sir.

Mr. RAYFIEL. How long, to your knowledge, has he been making those reports to the advisory board?

Dr. ADAMS. Since before the beginning of the Medical Council in 1924.

Mr. RAYFIEL. This advisory board that makes recommendations to the Administrator, this gentleman, and the others who are members of the advisory board, are they exactly the same gentlemen who are probably engaged by the AMA and by the FACAS to make these visits and reports?

Dr. ADAMS. This is a volunteer service of the American College of Surgeons.

Mr. RAYFIEL. And for approximately 24 years, then, you have been getting, as a member of the advisory board, these reports, is that correct?

Dr. ADAMS. Yes, sir.

Mr. RAYFIEL. In view of the revelations, shall I call them, that have been made here during the last 4 or 5 weeks you must have received reports indicating that the conditions in these facilities were, in many instances, bad and needed improvement, is that correct?

Dr. ADAMS. We have received no report directly on those hospitals which were criticized in the recent literature.

Mr. RAYFIEL. Should not that be due to the conclusion, then, that the reports which had been made were inaccurate?

Dr. ADAMS. I would not say so.

Mr. RAYFIEL. Surely, some of the matters that have been brought out by various witnesses and in published articles were true, were they not?

Dr. ADAMS. Whether the actual facts stated in those articles were true or not?

Mr. RAYFIEL. Yes.

Dr. ADAMS. I could not state, and I am not a competent witness on that because I have not personally examined the conditions reported in those articles.

I do know, if you are interested, that there was some material in those articles which did not state the whole fact. I would cite one instance in the first article appearing in the Reader's Digest and in the Cosmopolitan in which it was stated that during a period of 3 months although Mount Alto Hospital was designated as one of the thoracic surgery centers in the Veterans' Administration, only eight operations had been performed during that 3 months, and that those were all pneumothorax, which is not a surgical procedure in the usual sense of the word anyway.

Now, the inference was that here was a hospital designated as a thoracic surgery center doing no thoracic surgery in spite of the fact that there were a considerable number of patients in the hospital at that time suffering from tuberculosis. The writer either did not know, or did not take the trouble to inform himself, that the hospital was operating as a diagnostic center.

Mr. RAYFIEL. I do not suppose, Doctor, that anybody insists or believes that all or nearly all of the charges which were made were true, but the Administration itself from time to time has admitted the existence of certain conditions that were complained of. I think that has been established. Let us assume that is a fact, and generally I am certain that it is, do you not think that the gentleman who investigated these various facilities during the years has failed to report accurately as to those conditions?

Dr. ADAMS. No, sir; I could not answer that question in the affirmative. In the first place, the condition in veterans' hospitals during the past 2 or 3 years has been much worse than it was prior to that time as it is in civilian hospitals and even in university hospitals, so that any report made 2 or 3 years ago could represent conditions quite accurately at that time but would not represent the present status, particularly as it pertains to personnel.



There has been such a rapid turn-over in personnel, such a hungry grasping for any kind of help that could carry over during the time when help was just completely inadequate that things have happened that would not happen under any ordinary conditions.

Mr. RAYFIEL. Has that affected equally the quality of the medical help, too—the doctors?

Dr. ADAMS. Yes, sir.

Mr. RAYFIEL. But you stated a little while ago that you thought that the medical help in veterans' facilities was on a par with that in other institutions.

Dr. ADAMS. I still think so, sir.

Mr. RAYFIEL. In other words, you think they are below the normal, ordinarily?

Dr. ADAMS. I would except the Army and Navy hospitals at the present time.

Mr. RAYFIEL. Of course, you also would want to except the medical facilities connected with educational institutions?

Dr. ADAMS. Even those have suffered. They are on a higher plane than the usual facilities, but even those have suffered seriously.

Mr. RAYFIEL. That is all.

Mr. RAMEY. In the inspection of veterans' facilities and hospitals, where we notice a mistake or failure that is emphasized. If we notice 100 that are all right, that does not receive attention, is not that correct?

Dr. ADAMS. That is true in most things.

Mr. RAMEY. I know I had an unusual situation in the Dayton Facility. I had three cases there that were very bad, and there were perhaps 1,900 that were good. The 1,900 received no attention, but the three that were mentioned as bad always received notice.

I am concerned about your bill, and believe it should be adopted. There are one or two matters that are receiving my attention. Now, Doctor, the veterans above all things want recognition. They want to be noticed if they are in a hospital, even in a private hospital, and they want to see their doctor, and want to talk to him. The veteran sees the doctor, perhaps, for 5 or 10 minutes a day, and then there is a nurse in the ward here, and she is in a room where her medicines and equipment and so forth are, and the light goes on indicating that a veteran wants some attention, and he may get some attention from the nurse, but the attendants do the work. It seems to me that we have forgotten the attendant. He does the drudgery. He has no professional skill, but he has the drudgery to do, and right now it is quite difficult to get attendants for those hospitals. For instance, at Brecksville, near Toledo, Ohio, it is difficult to get an attendant at \$110 a month when a laborer gets \$75 a week, or in a hospital close to Detroit where the laborer receives \$100 or \$125 a week. It is difficult to get an attendant, and it is just practically impossible for you to get one you can depend upon.

Now, if this bill were adopted, is it possible that the Surgeon General could work something out so that veterans of this war who desired to become attendants could make a career out of it if they desired to, so that they could be called by some more dignified name than an attendant, such as associates, or technicians, so that it could be made a career? They are especially needed at NP hospitals. For instance, at Dayton there is one of the best surgeons in the country. He could

get nurses but not enough of them, but when you get to the attendant he is the man who is constantly with that veteran and who waits on him. Your veteran says, "I do not see the doctor enough, I do not get the opportunity to talk to him." For instance the veteran returning from overseas says, "In the hospital I was in overseas I got attention, and when I come here I am just forgotten. I am just sort of pushed around." They have that feeling. Do you think we can depend upon the Surgeon General to say, "Well, at least that attendant is one that stands by the patient all the time; we will give him a sympathetic attitude in his work, as he is part of us," or would there be danger of the medical men in charge and the nurses talking to those attendants who do menial tasks in a sort of imperious voice and just ordering them around? Do you think that we can have a solution of that, as that seems to be one of the difficult things that I found in my visits?

Dr. ADAMS. Sir, I would say that if what you have in mind and what you have expressed could be accomplished, it would be a Utopia beyond any doubt. It has always been, even before this emergency or the previous one, a very difficult thing to get good attendants in veterans' hospitals, in university hospitals, or in hospitals in general. I am not seriously impressed with the desirability of trying to get too much confidence by patients placed in attendants. If attendants can do the work which they need to do, I think that is about as much as we can ask of them. I would be much more interested in the liberation of a larger number of physicians to attend to the human side of medicine in connection with those patients, as well as doing development work and more or less scientific work in connection with the patients. In the last analysis I think most patients—this does not apply to some who are in neuropsychiatric hospitals and who are completely appreciative of things as they are—I think that the actual need of the sick man is the knowledge that some physician who knows what to do is personally interested in him.

Mr. RAMEY. That is, you would bring enough physicians in so that the patients would get that sympathy and attention?

Dr. ADAMS. I would not know about that. If it did not work, it should be liberalized as conditions determine.

Mr. RAMEY. I have seen a great many veterans that did not sleep well, and they can sometimes get into the dispensary room on their floor, and they get barbitol, luminal, and so forth. That, of course, is not a derivative of morphine, but is there not grave danger of its being habit-forming? I suppose a great many doctors give them to people when they do not sleep?

Dr. ADAMS. Of course, there is a danger. The barbitol group is habit-forming to a considerable degree, but I think that more than just average care is used in the dispensing of sedatives and narcotics in general.

Mr. RAMEY. It does not leave them permanently injured in any way?

Dr. ADAMS. Usually not. There are exceptional cases where it is taken inadvisedly and where it does do damage.

Mr. RAMEY. There are quite a few veterans, quite a few soldiers fighting very hard with people about two or three faiths. For instance, we will say the Christian Science faith. A Christian Scientist lands in a veterans' hospital, and I have always found the doctors seem very tolerant. You do not hear any of them saying, "You can't have a practitioner here; that is just taboo. We will make a rule against any of

them visiting." The doctors I have seen say they would rather have somebody like that rather than a hypochondriac. There cannot be any danger of their making a rule and saying, "We will not allow a practitioner to come in here." Sometimes those practitioners are better than psychiatrists. They have more cheer. I do not mean that they are used in place of medicine. I believe the American medical fraternity would not just have those physicians say, "We will not allow any veterans of those faiths to even have attention." You do not think there is any danger of that happening, do you?

Dr. ADAMS. I would not be in a position to express any opinion as to the attitude in the administration of medicine as related to some of the other practices in veterans' hospitals for the future. I would say that the general attitude of most of the practitioners of medicine whom I know is that if patients will do what they feel is essential medically and surgically, then any additional help which they may get which does not interfere with carrying that out is a thing not to be resented.

Mr. RAMEY. Thank you, Doctor.

Mr. McQUEEN. Doctor, I want to ask you with reference to Mount Alto Hospital. In addition to the fact that you have served for a number of years on the medical advisory group, you have been a consultant at Mount Alto Hospital; is that true?

Dr. ADAMS. Yes, sir; since 1925.

Mr. McQUEEN. Mount Alto is operated by the Veterans' Administration, is it not?

Dr. ADAMS. Yes, sir.

Mr. McQUEEN. How does that hospital, the Mount Alto Hospital, compare with other hospitals here in Washington?

Dr. ADAMS. Very favorably, sir.

Mr. McQUEEN. Is the staff at Mount Alto sufficient to care for the patient load that they have there, together with the consultants?

Dr. ADAMS. It is not at the present time.

Mr. McQUEEN. Is it properly staffed for a hospital such as it is?

Dr. ADAMS. It is not properly staffed at the present time, particularly in the neuropsychiatric department.

Mr. McQUEEN. You have had occasion to observe the operation and the conditions at Mount Alto for a number of years?

Dr. ADAMS. Yes, sir.

Mr. McQUEEN. In your opinion, have the conditions which prevail out there been satisfactory for the treatment of veterans or anyone else?

Dr. ADAMS. In the main, the answer would be "Yes." The whole building outlay is antiquated, inconvenient, difficult to administer, because of the fact that it was a girls' school before it was taken over as a hospital, and consequently it is not planned with the idea of being administered as a hospital. But the administration of it and the general medical care, even from the testimony of many of the physicians transferred to that hospital, is on a very high plane.

Mr. McQUEEN. I think that is all, Mr. Chairman.

Mr. DOMENGEAUX (presiding). Do you have any questions, Mr. Carnahan?

Mr. CARNAHAN. I did not hear the doctor's statement, but I would like to ask how the veterans' hospitals rate in comparison with civilian



hospitals in such things as occupational therapy, recreational therapy, and things of that sort. Do they provide as good a program as the civilian hospitals, or better?

Dr. ADAMS. If you take the civilian hospitals in an average, the vocational training or the subsidiary work in that connection, they are superior to the average hospital.

Mr. CARNAHAN. You mean that the veterans' hospitals are superior?

Dr. ADAMS. Yes. Most of the ordinary civilian hospitals do practically nothing of that kind. I am not speaking now of the State institutions. If you are speaking of State institutions, my answer would probably have to be different; but if you are talking about the hospitals—

Mr. CARNAHAN. I was asking about the general hospitals, but I will ask you in reference to veterans' hospitals as compared with State institutions.

Dr. ADAMS. I would not feel in a position to answer that question with authority, and I would prefer that you put it to someone else.

Mr. RAYFIEL. Doctor, I would like to ask you a question about Northport particularly. I happen to have visited that hospital. Your practice is general medicine?

Dr. ADAMS. Internal medicine.

Mr. RAYFIEL. But your connection with the advisory board puts you in position to learn something about psychiatric facilities, too?

Dr. ADAMS. Yes.

Mr. RAYFIEL. I want to ask you what your opinion is as to the relative value of insulin treatment as against electric-shock treatment.

Dr. ADAMS. May I beg to be excused as far as answering that question is concerned. I do not feel in any way qualified to answer a question that could be so much better answered by some of the members of the neuropsychiatric group. My opinion would be worth nothing, and, consequently, I should prefer not to offer it.

Mr. RAYFIEL. All right.

Mr. DOMENGEAUX. Doctor, since the last war there was little that the Veterans' Administration had to offer in the way of remuneration and in the way of opportunity for professional attainments to a competent, outstanding young medical graduate who was about to start in his profession, or a successful practitioner, to enter the Veterans' Administration service. Is that correct, sir?

Dr. ADAMS. I think, as compared with some of the other opportunities in medicine, that statement is correct, sir.

Mr. DOMENGEAUX. This may be unfair, but is it not a fact that a doctor who became connected with the Veterans' Administration since the last war was usually a doctor of the type that had been unsuccessful in their attempt to practice medicine, or not as successful as they had hoped, and also to a great extent doctors who had been unsuccessful in establishing a practice?

Dr. ADAMS. I could not answer that question, sir, in the affirmative.

Mr. DOMENGEAUX. Can you answer it in the negative?

Dr. ADAMS. I think that a very considerable number of men of high professional attainments have remained in the Veterans' Administration because they found there an opportunity to do medical work. After all, it is the biggest medical opportunity in peacetime ever of-

ferred in the country. They have been interested in medicine and have remained in the Veterans' Administration where they could practice medicine and, at the same time, not be concerned about the competition outside. A certain number of doctors are thoroughly contented to be permitted to practice their art without too much competition, with an ample amount of material presented, and without what in general terms might be considered adequate compensation.

Mr. DOMENGEAUX. And also, Doctor, is it not true that very many also were definitely satisfied in drawing their monthly pay and getting their eventual pension? I do not want to be unfair about that. It is an observation that I have made and what some of the doctors in the Administration have admitted to me.

Dr. ADAMS. I am afraid that human frailty is not absent under the circumstances.

Mr. DOMENGEAUX. It is only natural?

Dr. ADAMS. Yes.

Mr. DOMENGEAUX. You say, Doctor, that the more ambitious doctor was satisfied because of the opportunity that the type of work he was doing gave him to carry on experiments?

Dr. ADAMS. Did I use that term?

Mr. DOMENGEAUX. No. I am just trying to sum it up. No; you did not use that term. The thought that I had was in connection with a hospital which gave a doctor an opportunity, because of the large number of cases of different types, to carry on his profession. That is generally what I gathered from you.

Dr. ADAMS. Yes, sir.

Mr. DOMENGEAUX. Is it not true that there is very little opportunity for independent thinking given and allowed to a doctor with the Veterans' Administration? Before he can do anything, practically he has got to get permission from the central office, permission from the parents, permission from the veteran, and actually he is hampered in the opportunity of development much more than he would be in normal practice or in a private hospital. Is not that correct?

Dr. ADAMS. I do not believe, sir, that unless one were experimenting in a new and untried and dangerous field the handicaps to a man operating along more or less recognized lines would be such as to—

Mr. DOMENGEAUX. Take the illustration of the treatment of mental cases by shock therapy, where the symptoms may indicate the desirability for immediate treatment. The patient cannot be given the shock treatment until permission is secured from the parents of the person responsible for that patient, and that may take weeks.

Dr. ADAMS. That is a question, again, that I do not feel particularly qualified to answer.

Mr. DOMENGEAUX. Dr. Griffith acknowledged that that regulation prevails.

Dr. ADAMS. I might say that in private practice the permission of some responsible person is obtained in the vast majority of cases before shock treatment is given such patient. That is a hold-over, practically, from previous more hazardous methods of giving the shock treatment.

Mr. DOMENGEAUX. On the other hand, Doctor, we all acknowledge that a large portion of a doctor's work is taken up with red tape, routine, and paper work. A doctor who was medical director at

Oteen, N. C., told me that 65 or 70 percent of the work there—I have his testimony—was taken up with routine, detailed paper work. With all of those requirements on the time of a doctor, how is he given the opportunity to grow and develop intellectually and spiritually in practicing his profession, which is essential, I think, for the development of a good doctor?

Dr. ADAMS. Sir, I can take no exception to the answer implied. The paper work, the administrative work, has been and is so cumbersome that it does seriously handicap the physician in the practice of his profession.

Mr. DOMENGEAUX. Is it not a further fact that the average doctor—is it certainly has been my experience—is so disgusted and disheartened with the requirements of the central office on his time and activities that after a short time he loses all interest and ambition and becomes largely the type of individual who is interested in the monthly pay and the eventual retirement? In many instances a man would have to be an extraordinarily strong character not to find himself in such a rut.

Dr. ADAMS. I think, sir, that too much time is and has been spent on doing matters not strictly medical, on the part of physicians.

Mr. DOMENGEAUX. Thank you very much, sir.

Mr. McQUEEN. Mr. Chairman, the Medical Director has other members of his advisory group here whom he would like to introduce to this committee, with their names and address for the record.

Dr. GRIFFITH. Mr. Chairman, you have a number of the representatives; and, for your information, we are having our executive council here for an administrative meeting and conference over in the Bureau and I have had the opportunity to bring them over to introduce the rest of them to the committee. They have not prepared any statements.

May I introduce, first, Dr. Irvin Abell, of Louisville, Ky., professor of surgery, University of Louisville School of Medicine; past president, American Medical Association; past president, Southern Surgical Association; past president, Gastro-Enterological Association; past president, Southern Medical Association.

Mr. DOMENGEAUX. We are happy to have you here, sir. I want to make the explanation that other members of this committee have been detained at other committee meetings, and I do not know that they knew that you illustrious gentlemen would be present this morning. That is the reason they are not in greater attendance. We are very happy to have you here. I might say this, too, that so far as I am concerned, I consider the medical testimony of these doctors one of the most important angles of our investigation. I consider this whole question a medical one, and their testimony and their advice and recommendations will be of great assistance to the committee.

If any of these gentlemen would like to testify, we would be very happy to listen to them.

Dr. GRIFFITH. May I complete the list?

Mr. DOMENGEAUX. Certainly.

Dr. GRIFFITH. The next is Dr. John Alexander, Ann Arbor, Mich., professor of surgery and surgeon in charge, section of thoracic surgery, University of Michigan School of Medicine; member subcommittee on thoracic surgery, National Research Council; chief surgeon, Michigan State Sanatorium; member of advisory editorial boards,



Journal of Thoracic Surgery, Review of Tuberculosis; International Abstracts of Surgery; and past president of American Association of Thoracic Surgery. Dr. Alexander.

Mr. DOMENGEAUX. How do you do, Doctor?

Dr. GRIFFITH. The next is Dr. J. Burns Amberson, New York City, professor of medicine, Columbia University College of Physicians and Surgeons; chief, chest service, Bellevue Hospital; past president, National Tuberculosis Association; and chairman, Subcommittee on Tuberculosis, National Research Council. Dr. Amberson.

Mr. DOMENGEAUX. We are glad to have you here, Doctor.

Dr. GRIFFITH. Dr. George E. Bennett, Baltimore, Md., adjunct professor of orthopedic surgery, Johns Hopkins University School of Medicine; attending orthopedic surgeon, Johns Hopkins Hospital; and member, committee on surgery, National Research Council. Dr. Bennett.

Mr. DOMENGEAUX. We are glad to have you here, sir.

Dr. GRIFFITH. Dr. W. Edward Chamberlain, Philadelphia, Pa., director, radiology, Temple University Hospital, professor of radiology, Temple University; member, National Research Council; American Radium Society; former chairman, board of chancellors, American College of Radiology, Radiological Society of North America. Dr. Chamberlain.

Mr. DOMENGEAUX. We are glad to have you, sir.

Dr. GRIFFITH. Dr. John S. Coulter, Chicago, Ill., professor, physical therapy and in charge of physical therapy departments, Northwestern University; American Congress of Physical Medicine; Council on Physical Therapy. Dr. Coulter.

Mr. DOMENGEAUX. How do you do, sir? We are glad to see you.

Dr. GRIFFITH. Capt. Erik G. Hakansson, United States Navy, medical director, Naval Medical Research Institute, National Naval Medical Center, Bethesda, Md. Captain Hakansson.

Mr. DOMENGEAUX. Captain, we are glad to have you with us.

Dr. GRIFFITH. Dr. Frederick W. Parsons, New York City, formerly assistant professor, psychiatry, University of Buffalo School of Medicine; former superintendent of Buffalo State Hospital, and former commissioner Department of Mental Hygiene, New York.

Mr. DOMENGEAUX. We are glad to have you here, sir.

Dr. GRIFFITH. Dr. O. H. Perry Pepper, Philadelphia, Pa., professor of medicine, University of Pennsylvania School of Medicine; member, board of regents, American College of Physicians; and chairman of committee on medicine of the Division of Medical Sciences, National Research Council.

The CHAIRMAN. We are very glad indeed to have you here, Doctor.

Dr. GRIFFITH. Mr. Chairman, I have introduced to you the entire group of physicians. The ones whom I have introduced have not prepared any statements to make before this committee, unless you want to interview them. If there is any one of them that you want to interview they will be glad to testify.

The CHAIRMAN. I have no particular questions in mind. I think the ones that you have presented here have just about covered the field.

Dr. GRIFFITH. Mr. Chairman, we have one whom we have not heard yet this morning—Dr. Lorenz. Shall I call him?

The CHAIRMAN. Yes.

STATEMENT OF DR. WILLIAM F. LORENZ, MADISON, WIS., PROFESSOR OF PSYCHIATRY, UNIVERSITY OF WISCONSIN MEDICAL SCHOOL, AND CHAIRMAN OF THE WISCONSIN STATE BOARD OF MENTAL HYGIENE

Dr. LORENZ. Mr. Chairman, and gentlemen, I have no formal statement to make, sir. Perhaps if I just rapidly outline my contact with the problem, I will then be subject to questions.

I have had contact with the neuropsychiatric cases that the Veterans' Administration handles from the time those cases develop in the field; that is, in the First World War. Then in about 1922 or 1923, when the American Legion formed its national rehabilitation committee, I was an adviser in neuropsychiatry to that national committee.

The CHAIRMAN. You are a professional psychiatrist?

Dr. LORENZ. Yes, sir.

The CHAIRMAN. You are a specialist in that line?

Dr. LORENZ. Yes.

The CHAIRMAN. What is your educational background, Doctor?

Dr. LORENZ. My secondary schools were in New York City: the New York University, and then the medical school of Bellevue Hospital, and New York University. I had my internships and residencies in New York, and then was in the New York State hospital service for about 6 years. I then went to Wisconsin and became affiliated with the University of Wisconsin and the State hospital service there. That is where I am at present, sir.

The CHAIRMAN. You are one of the consultants of the Veterans' Administration?

Dr. LORENZ. Yes.

The CHAIRMAN. How long have you been a consultant?

Dr. LORENZ. Since the beginning of the council, which I think was in 1924, or somewhere around that time.

The CHAIRMAN. You may proceed, Doctor.

Dr. LORENZ. For a period of time, until within the last few years, as a matter of fact, I have been a member of the council and also advisory member of the national rehabilitation committee of the American Legion. During that period of time I visited and made inspections of several Veterans' Administration neuropsychiatric hospitals.

Mrs. ROGERS. Will the gentleman yield? I remember, Dr. Lorenz, when you testified before our committee on 1925, I think it was, and then again at a later date.

Dr. LORENZ. That is right, Mrs. Rogers.

Mrs. ROGERS. Your testimony was very useful.

Dr. LORENZ. Thank you.

I might add that perhaps I should bring to this committee the viewpoint or experience of one who is much more familiar with the Middle West and with the sparsely populated areas of our country and with the South. I have been in many of the hospitals in Southern States, and certainly in the hospitals of the Middle West.

The CHAIRMAN. Have you been in the veterans' hospital at Gulfport?

Dr. LORENZ. No. I have made no regular inspection. I made a visit there, but no regular inspection. That was 3 or 4 years ago in making a tour of inspection of the civilian State hospitals in the South at the request of the National Committee on Mental Hygiene. That included Louisiana, Georgia, and Tennessee. I suppose Tennessee would be regarded as a Southern State. Those were the principal institutions that I visited at that time. The point is that I am in position to at least offer information as to the work done in Veterans' Administration hospitals for mental cases as compared with the average State hospitals.

The CHAIRMAN. How do they compare?

Dr. LORENZ. Decidedly in favor of the Veterans' Administration hospitals.

The CHAIRMAN. Why do you say that, Doctor?

Dr. LORENZ. I say that on the basis of what I have observed, what I found. In the first place, there is one thing that is history that must be said in commendation of the Veterans' Administration. When they began, they started from below scratch, so far as buildings were concerned. In the course of the last 20 years the construction department of the Veterans' Administration especially had done an outstanding job, in my judgment. The type of structure, the arrangement of buildings, the whole thought and plan of service to the patient have been very thoughtfully carried out in the physical structure; and that really was a pioneering effort, because prior to that time there was no standardization whatsoever. I can say that many States might in the future be guided by the experience of the Veterans' Administration and their accomplishment in the field of construction alone, so that from a physical standpoint, a physical structure standpoint, the Veterans' Administration hospitals, with very few exceptions, are far better than any State, county, or municipal hospital of a thousand beds or more, that I know of, in the Middle West or in the South.

The CHAIRMAN. What importance do you attach to the psychological advantage that a veteran derives from the standpoint of being placed in a veterans' hospital instead of going to a State insane asylum and having that stigma attach to him, if it can be called a stigma?

Dr. LORENZ. There is a tremendous advantage in having the veteran hospitalized with those of his own group, where they have had common experiences. After all, a veteran, even when he is quite mentally incompetent, is still quite conscious of the fact that he has been a soldier. So that because of their common experience and the carrying over of a lot of experiences of a soldier into his veteran state, it is a decided advantage in treating him and in stabilizing him and in seeking to cure him, rather than mixing him with those who came from a different background.

The CHAIRMAN. Do you have a written statement, Doctor?

Dr. LORENZ. No, sir; I have not.

Mrs. ROGERS. I would like to ask the doctor a question.

The CHAIRMAN. Are you through with your statement, Doctor?

Dr. LORENZ. Not entirely, sir. I have made some notes.

Mrs. ROGERS. Go ahead and finish, then, and I will ask you some questions afterward.



Dr. LORENZ. I made some inspections—not mere visits—of hospitals or facilities—I don't like that term—operated by the Veterans' Administration at Galesville, Ill., Chillicothe, Ohio, Perryville, Md., Coatesville, Pa., Leavenworth, Kans., St. Cloud, Minn., the Hines Hospital, the Mendota facility in Wisconsin, and the facility at Wood, Wis.

I wish to say that in making those inspections I follow a certain method that I choose to call an audit. Not a financial audit, by any means, but a human audit. In other words, I go to those places, of course authorized by the Administrator, but unannounced. I then request the manager to give me a list of the cases that were admitted during the previous 2 months. Then I will take 20 or 30 of those cases as they run—the “mine run,” no exceptions—and arrange them for a personal private interview with each such patient, alone in a room. I ask for the medical record such as they have made up to that time. Then I have this interview. I size up the patient, study the record, and am able to judge to a degree, at least, how much of this person's mental disorder and illness appears in the record. Then I note particularly what program of treatment, and so forth, has been proposed; and if perchance I have some idea as to trying out some other form of therapy at the second day or the third day I will discuss some of these cases with the clinical director or the junior members of the staff.

I call that auditing the patient. I find that they do make very careful audits of all property and money, and so forth, down to a penny, but I think the auditing of the patient is probably equally important.

The CHAIRMAN. Your opinion of the Veterans' Administration has been based on your experience in that respect?

Dr. LORENZ. It has been based on the direct personal contact with patients, and not by mere hearsay or casual observation.

The CHAIRMAN. You rate them, on the average, better than the State institutions?

Dr. LORENZ. Pardon me, sir?

The CHAIRMAN. You rate the veterans' mental hospitals, then, as better than the State institutions?

Dr. LORENZ. With very few exceptions; yes, sir.

Mr. DOMENGEAUX. Do we not spend more per patient per day for the administration of veterans' hospitals than we do for State institutions?

Dr. LORENZ. Yes.

Mr. DOMENGEAUX. So, consequently, the service should be much better?

Dr. LORENZ. It should be.

The CHAIRMAN. And there is more room and there is not so much overcrowding of patients as in State institutions?

Dr. LORENZ. That is correct.

The CHAIRMAN. I have driven by a few State institutions and have heard awful screaming. I have never known that condition to prevail in a veterans' hospital. Of course there are a few that are noisy, but as a rule they are placed where they do not disturb the other patients.

Dr. LORENZ. On the basis of my experience—and I have a background of State hospital service and am quite familiar with State

hospitals—I can state very honestly that right today I believe the veteran who is suffering from a mental ailment is receiving better care and better treatment than his sister or his brother or his mother or his father who might be unfortunate enough to be suffering a mental ailment.

The CHAIRMAN. Is it not your experience that thousands of these boys that have gone to these institutions have come away practically cured and found their place back in civilian life and are now moving along as if nothing had ever happened to them?

Dr. LORENZ. Yes, sir.

The CHAIRMAN. Without the stigma of having been an inmate of an insane asylum?

Dr. LORENZ. That is true.

The CHAIRMAN. I am just wondering why the press does not give the American people that side of the picture.

Dr. LORENZ. Yes. It is unfortunate.

The CHAIRMAN. It certainly is.

Mrs. ROGERS. Dr. Lorenz, is not one reason that you do not hear so much screeching in the veterans' hospitals as in the State hospitals that they have more of the continuous baths?

The CHAIRMAN. Are you talking about delirium tremens? That means seeing snakes from drinking too much liquor.

Mrs. ROGERS. The continuous baths?

The CHAIRMAN. Delirium tremens.

Mrs. ROGERS. I did not say anything about that. I said that you did not hear so much screeching in the Veterans' Administration hospitals because they put the men in the so-called continuous baths.

Dr. LORENZ. Yes, Mrs. Rogers. The hydrotherapeutic equipment was the finest from the standpoint of apparatus and control and adequacy. It compares with the best we have in the East, including your State of Massachusetts, which is outstanding, of course, in that respect—or New York. Right at this moment they are very well equipped, and without any doubt the handling of that most difficult problem, the disturbed case, is made possible by this hydrotherapeutic equipment, books, and all the other means that they use to medically handle that clinical problem.

Mrs. ROGERS. Every disturbed patient has, I think, about twelve of the continuous baths?

Dr. LORENZ. Yes. And then another thing: I found at these hospitals a real effort at classification. They did not mix up their patients with actually disturbed cases that required more attendants, more service, this hydrotherapy. They were all conveniently grouped in one section and not mixed up with the general population of the hospital. That is very important.

Mrs. ROGERS. But you did find overcrowding, did you not?

Dr. LORENZ. Yes.

Mrs. ROGERS. I think that is a very unfortunate situation, both in the day rooms and in the dormitories.

Dr. LORENZ. Yes.

Mrs. ROGERS. Doctor, do you inspect at night when you are inspecting hospitals?

Dr. LORENZ. Oh, yes. In my inspections I have carefully avoided the usual social amenities, being a visitor there, and so forth and so on.

I never stayed at an institution. I commonly spent 2 or 3 days there, but I lived at a nearby hotel. In some instances, as an example of arriving unannounced, I went to one institution and could not find a conveyance, could not hire anything. It was a distance of about 5 miles to walk by road. Someone told me that if I jumped a 7-foot fence I would have only a mile to go. So I introduced myself into that institution by jumping a 7-foot fence, in spite of the fact that I am not an athlete any longer, and went into the back yard. I am citing that example of avoiding things that interfere with a proper evaluation of an institution, avoiding any of the personal relationships that otherwise might obtain.

Mrs. ROGERS. How about the giving of drugs to disturbed patients in Veterans' Administration hospitals as compared with the giving of drugs in State hospitals?

Dr. LORENZ. In the institutions where I visited I know they followed the recognized methods with regard to all drugs like the barbitrates and narcotics, in fact, any drug that is, by prescription only, and a record is preserved of that, and no nurse gives them unless the orders read "PRN" in certain emergencies. The giving of drugs and the handling of such problems in the institutions that I visited are in accord with the best medical practice.

Mrs. ROGERS. But they are brought in, are they not, by attendants and others?

Dr. LORENZ. The actual giving of the drug to the patient is done by personal—

Mrs. ROGERS. No; I mean persons visit the hospital, visitors bring in drugs, and I have also understood that attendants do, too.

Dr. LORENZ. That I do not know.

Mrs. ROGERS. Did you investigate the hospitals where the beatings took place?

Dr. LORENZ. No. I was requested by the Administrator to visit Northport, but I could not make it at that time. I think Northport was one of them.

Mrs. ROGERS. Yes. I think there were 16 beatings and at other hospitals they were admitted. I wondered if you had any suggestions as to how that sort of horror could be stopped. It should not be tolerated. It must be stopped.

Dr. LORENZ. I have a suggestion. I am not so certain of the wisdom of it, but I will be free to express it with some reservations. I am inclined to think that the physician in charge should be permitted more autonomy, more authority in exercising discipline or disciplinary measures upon attendants or others—I mean by discharge or relief from duty—so that they can act promptly. I am inclined to think—I do not know for certain—that in some instances they have not got that authority, and they must refer to the central office for action.

The CHAIRMAN. Doctor, the testimony here shows that some of the mistreatment of those inmates at Northport was done by Negro soldiers over which the management of the hospital had no control.

Dr. LORENZ. Yes.

The CHAIRMAN. And they have been court martialed and punished.

Dr. LORENZ. Yes. I read some of that.

The CHAIRMAN. That was the testimony before the committee.



Mrs. ROGERS. But the beatings are not confined to colored people.

The CHAIRMAN. There are some white attendants, and they are being prosecuted now.

Dr. LORENZ. Those things happen in all our hospitals, the very best hospitals.

Mrs. ROGERS. Are there more beatings in civilian hospitals or more in the Veterans' Administration hospitals, do you think? Have you any figures or statistics on that?

The CHAIRMAN. If you do not want to answer that question, I will sustain an objection to pinning you down to any State hospital. Just give a general answer to that question.

Dr. LORENZ. My general answer is this, and I say this advisedly. It is my firm belief that there is far less abuse, far less mistreatment in a physical way or any other way, of a veteran in a veterans' hospital than can obtain and does obtain to civilians in civilian hospitals.

Mrs. ROGERS. Is that because there are more nurses and more attendants?

Dr. LORENZ. I think it is because it is a policy. I think there is an attitude of protection that is thrown around a veteran. I think that that stems right from the central office all the way down. The rules and regulations and the practices required by central office regulations are of an extraordinary character. In fact, I think they go beyond what is necessary to protect the patient from abuse and mistreatment. The managers, without exception, are very much concerned about that.

The CHAIRMAN. Doctor, can you be back at 1:30?

Dr. LORENZ. Yes, sir.

Mrs. ROGERS. I had not quite finished.

The CHAIRMAN. I know; but the House is meeting.

Mr. DOMENGEAUX. I would like to ask one question, but I do not want to go ahead of Mrs. Rogers.

Mrs. ROGERS. Doctor, is it not true that one reason that conditions are better in the Veterans' Administration hospitals is because they have the American Legion and other organizations, and people coming in and out all the time?

Dr. LORENZ. Without any doubt, that is very effective. There is no group of patients that has such an interest voiced in their welfare as the veteran, because of the veterans' organizations.

Mrs. ROGERS. In 1925 you endorsed a bill for a medical corps, a similar measure.

Dr. LORENZ. Yes; I did.

Mrs. ROGERS. Thank you.

Mr. DOMENGEAUX. Doctor, I think we agree that it is inevitable that brutalities will creep into hospitals that are of such magnitude as these. The human element always enters, but it can be minimized. What we are all interested in is minimizing these occurrences as much as possible; and you stated that giving more authority to the management would help bring this about. In the Northport case I believe it was testified by the manager that he was unable to find out or to secure any evidence of these occurrences, and that they only came to light when undercover men were placed there. Do you not think that that is really the only way that you can have a check on the inclinations of an attendant to let his emotions get the best of him, by having a

safeguard in the form of an undercover man who may be at any time watching?

Dr. LORENZ. I agree with you insofar as the desirability of having some force outside or not directly a part of the administration make such contact as to be able to detect the hidden cases of using a towel around the neck, and so forth, which is not an uncommon practice.

I would like, for that reason, to cite one of the reasons for my personal interview with these patients. That is always a part of the inquiry. You have got to be well informed as to a mental state to separate facts from fancy, however, but you can by that audit of the individuals detect instances of abuse or mistreatment which escapes the attention of the management. I think a strong inspection service, a powerful inspection service, that is wholly removed from any possibility of pressure or influences of any kind, is a very, very important thing in the operation of a large number of institutions dealing with mental disorders.

New York State adopted such a policy years ago and, as far as I know, it still continues, so that the patient away back in these big wards that ordinarily might be forgotten is audited by some very responsible authority that has authority greater than that of the management.

Mr. DOMENGEAUX. But there is an inclination on the part of attendants to defend and protect and hide the activities of their co-workers.

Dr. LORENZ. There is no doubt about that.

Mr. DOMENGEAUX. And that is a natural inclination.

Dr. LORENZ. An attendant will get some strong patient, I understand, to do the job for him. They teach others to use these physical means of restriction or punishment.

Mr. DOMENGEAUX. I might say, further, Doctor, that although I certainly cannot testify as an expert, as a layman, in visiting some of these mental hospitals of the Veterans' Administration and going through with some of the doctors and the directors, to my mind I saw a great feeling of affection that existed in the faces of these patients for their directors and doctors and many of their attendants, which certainly, to me, indicated that they were treated at least kindly.

Dr. LORENZ. You are very correct in that observation.

Mr. DOMENGEAUX. Is it desirable that in these mental hospitals there should be more doctors and psychiatrists and experts in mental diseases? At Gulfport, Miss., for instance, I found that in a hospital of some seven hundred and fifty-odd patients—maybe a little more or a little less—there were only three psychiatrists, men who had had previous experience.

Dr. LORENZ. Certainly there should be leadership. I mean, a very competent clinical director. The manager should be a good neuropsychiatrist, and the senior group should be experienced and highly qualified men. You can infiltrate the younger element in there who are getting practical experience and, by staff meetings or other means, are being developed. They need not be 100-percent neuropsychiatrists right down to the lowest grade of medical member of the staff. At all mental hospitals you have got to have physicians who represent other fields of medicine.

Mr. DOMENGEAUX. Of course. At this very same hospital I found an X-ray man who had had no previous experience in X-ray work before he had been placed in that assignment, and there was eye, ear, and throat specialist who had had no previous experience.

Dr. LORENZ. In the last year or so I have found that to be true in some of these institutions. They are not to be blamed for that. That obtains all over, and men have been temporarily assigned to a specialty because no one else was available. That is just due to the unfortunate general situation that obtains.

Mr. DOMENGEAUX. Thank you.

Mr. McQUEEN. Doctor, there has been a good deal said about the NP hospitals and the use of shackles or restraints. Can you give the committee the benefit of your information on restraints of patients?

Dr. LORENZ. There were six veterans' hospitals for mental diseases that I surveyed and spent sufficient time in and went around alone and did not accept merely information, but sought by all means that I possessed, and I found four cases in which there was physical restraint used, and in each one of those cases I would have ordered it myself. We operate a psychopathic department at the university hospital and we have to use physical restraints every once in a while. It is humane; it is necessary for a patient's welfare.

Mr. GIBSON (presiding). It is necessary for the protection of the party on whom you use it?

Dr. LORENZ. Yes, certainly. It is not abused in the veterans' hospitals that I visited.

Mr. GIBSON. Do you have anything else to offer, Doctor?

Dr. LORENZ. No, sir.

Mr. GIBSON. You may come back at 1:30 if you have. If you have not, I do not know of any reason why you should come back.

Dr. LORENZ. I am here in town and am available to the committee.

Mr. GIBSON. We will take a recess now until 1:30 this afternoon.

(Whereupon, at 12 m., a recess was taken until 1:30 p. m. of the same day.)

#### AFTERNOON SESSION

The CHAIRMAN. The committee will come to order. We will hear this afternoon from Dr. Murphy. Dr. Murphy, will you be sworn?

#### STATEMENT OF CHARLES P. MURPHY, LIEUTENANT COLONEL, MEDICAL CORPS, ARMY OF THE UNITED STATES

The CHAIRMAN. Give your full name, Doctor.

Dr. MURPHY. Charles P. Murphy.

The CHAIRMAN. Doctor, where were you educated?

Dr. MURPHY. University of Oklahoma.

The CHAIRMAN. When did you finish there?

Dr. MURPHY. 1912.

The CHAIRMAN. That was your literary degree?

Dr. MURPHY. And my medical.

The CHAIRMAN. Where did you take your literary degree?

Dr. MURPHY. In Oklahoma.

The CHAIRMAN. Are you a native of Oklahoma?

Dr. MURPHY. Native-born Kansan, but I guess by adoption an Oklahoman, like the rest of the others down there.



The CHAIRMAN. All right. Will you state your position?

Dr. MURPHY. I am manager of the veterans' facility at Livermore, Calif.

The CHAIRMAN. Is that an NP hospital?

Dr. MURPHY. No, sir; it is for the treatment of tuberculosis.

The CHAIRMAN. Tubercular hospital?

Dr. MURPHY. Yes, sir.

The CHAIRMAN. That is at San Francisco, is it?

Dr. MURPHY. No, sir; it is about 40 miles east of Oakland, about 50 miles this side of San Francisco.

The CHAIRMAN. Is there a veterans' facility at San Francisco also?

Dr. MURPHY. Yes, sir.

The CHAIRMAN. What is it called?

Dr. MURPHY. Fort Miley.

The CHAIRMAN. What is it for?

Dr. MURPHY. General medical and surgical.

The CHAIRMAN. All right, Doctor. If you have any statement to make, you may proceed; if not, counsel will ask you questions.

Mr. McQUEEN. I might say, Doctor, that the reports that were submitted by the American Legion and the Veterans of Foreign Wars, were very adverse to good treatment at the hospital at Livermore, and on the basis of that, I am going to read you the first question that was asked.

The CHAIRMAN. Before you come to that, let me ask you this: What is the capacity of that hospital?

Dr. MURPHY. Bed capacity for the day is 462.

The CHAIRMAN. How many patients have you?

Dr. MURPHY. About 315.

The CHAIRMAN. You have 135 vacancies, then?

Dr. MURPHY. Yes; we have a number of beds we have not been able to fill on account of the help situation. Personnel is very difficult to obtain in that area because we are very near the defense area which makes it very difficult.

The CHAIRMAN. Proceed.

Mr. McQUEEN. The first question in this series of questions that the three veterans' organizations sent out reads this way:

Are there any general or specific complaints on the medical treatment and the hospital care received by the patients and if so, please describe briefly.

Here is the answer to that question:

Patients in this hospital have nothing but complaints regarding the medical care that they received, and I have been visiting this place regularly for almost 11 years. In the past year the complaints have been so numerous it now almost becomes unanimous.

Under that he has:

(a) Chief complaint is the fact that all of the ward doctors do not like the manager and the clinical director, as they do not cooperate with the ward doctors, use high-handed tactics in dealing with the doctors, and personally it reflects upon the care of the patients.

Then—

(b) I talked to several of the doctors in person and while they are afraid to make specific complaints to a civilian because most of them are in the Army uniform, it is felt that a complete investigation by proper authorities should be made at once.

Under "(c)" he says:

The situation is so desperate that I think the manager and clinical director should be relieved of their commands immediately.

Now, with that general basis, Doctor, if you have any statement you want to make, why, go ahead and we will question you from there.

The CHAIRMAN. Whose statement were you reading from, Mr. McQueen?

Mr. McQUEEN. I was reading from the statement submitted by the American Legion, signed by Charles R. Farrington, department service officer, but the report is unsigned. The American Legion representative could probably tell us who made that report a little later.

The CHAIRMAN. We should like to know.

Mr. KRAABEL. Mr. Chairman, the transmittal originally is approved by Charles C. Galiano, chairman of the rehabilitation commission, Department of California.

Mr. McQUEEN. It is not the report of Mr. Farrington.

Mr. KRAABEL. Farrington made the report for these people, and he approved it, but the report itself, which we have, is not signed.

Mr. McQUEEN. That is the way this one is.

Dr. MURPHY. I would like to go over those charges specifically. In regard to the first statement that the patients have nothing but complaints regarding the medical care, that is only a statement of one man who went around and visited a certain number of patients. Mr. Farrington was probably in the hospital 3 hours, not more than that. I don't believe. They were in my office at about 11 o'clock, he and Mr. Mulcare. Then they went over to talk to the clinical director, and they went to the hospital and left there about 3:30, and how many patients he could have talked to out of the 315 I do not know, but he could not have contacted nearly all the patients, so I would have to say that was not the statement of all the patients.

That is the best I could say.

Now, if there have been complaints in the past year, they have not come to our attention. If the American Legion have had them or if any other organization has had them, they have not brought them to our attention, except one, I believe. Mr. Mulcare brought one to my attention about some of the boys claiming they could not get fruit.

We checked on that and did the best we could on it.

The CHAIRMAN. Could not get what?

Dr. MURPHY. Fruit. Mr. Mulcare brought that to my attention and we corrected it as far as we could.

Now, the chief complaint here, that they do not like the manager and clinical director, that is not a fact with all the doctors. You might say, against the clinical director and myself; now, that is true that we have tried to follow regulations and we do not think we have been too hard, but several of them want more privileges than you can give them today, and to say that none of them like us is a misstatement, because I can get statements from doctors out on the post there that will be in accord with the management. I am sure, and with the clinical director, because two of them came and talked to me just before I left there about it and said they were sorry this thing came up, and they knew there were no facts in these things, or in many of them, at least; and others, I am sure would; there are certain ones that would give us a bad report on us, I am sure.

Mr. McQUEEN. How many doctors have you there, Doctor?

Dr. MURPHY. We have 11 there now, with the dentist.

Mr. McQUEEN. Is that your full quota?

Dr. MURPHY. No; we are one short of our quota. We have one man away sick who has been sick since February, so we are two short of our quota.

Mr. McQUEEN. Go ahead.

Dr. MURPHY. No, this (b) where he says he has talked to several of the doctors in person where they are unwilling to make a statement to civilians because most of them are in the Army uniform, and so on, and so forth, I would welcome that investigation very much, sir, but by a fair-minded group. I would not draw any line as to who it is. I do not ask for anybody; if they want to do that, either the Administrator or the organizations, I would welcome it if they would give us an investigation by a fair-minded group.

I do not believe I am in a position to answer this third paragraph (c):

The situation is so desperate that I think the manager and the clinical director should be relieved of their command immediately.

I do not believe it is my place to answer that one.

That is all I have to say on that first question, I believe.

The CHAIRMAN. What was that man's name that made this report?

Dr. MURPHY. Mr. Farrington. He was the man who was out there.

The CHAIRMAN. Well, the man that made it is another man, what is his name?

Mr. KRAABEL. Mr. Chairman, the chairman of the rehabilitation committee, Department of California, Charles C. Galiano, approves the report, apparently Farrington, a paid employee, made it for him.

The CHAIRMAN. I see. Any questions, Mr. Scrivner?

Mr. SCRIVNER. Yes; I have a couple, Mr. Chairman.

Doctor, you said you would welcome an investigation by a fair-minded group?

Mr. MURPHY. Yes, sir.

Mr. SCRIVNER. Am I to infer from that that you think possibly the representative of the American Legion and possibly the VFW, who made the report, were not fair minded in the thing?

Dr. MURPHY. Well, I would have to question the American Legion's representative in that; yes.

Mr. SCRIVNER. Why?

Dr. Murphy. About a year ago, the chief of the contact service for San Francisco, brought in an employee who was to act as contact representative at our facility. This employee had been on duty at one of the naval hospitals in our vicinity and apparently he had not gotten along well over there. The chief brought this contact representative in to me and introduced him and said he would be with us and then he goes out with the man and in a few minutes, this chief of contact came back, and he said to me, "now, you let us know how this man gets along."

Mr. SCRIVNER. What man are you referring to now?

Dr. MURPHY. This contact representative they were assigning to our facility.

Mr. SCRIVNER. What was his name?

Dr. MURPHY. Mr. Gordon. So the man came to work and his work was not satisfactory. He was not dependable; he would not report



many days, and we would never know where he was, and I kept reporting this to San Francisco because he was under that office, under the chief of contact in San Francisco.

A little later, this man was relieved from duty by the Civil Service. However, the chief of the contact service in San Francisco told me they were getting ready to let him out because they were not getting the service they expected from a contact officer.

Now, this Mr. Gordon was apparently a friend of Mr. Farrington, and in a short while—I do not know just how soon after he was released from the Veterans' Administration—was appointed assistant adjutant in the office in San Francisco. That is, assistant adjutant for California. For that reason, I feel that Mr. Farrington probably felt that I was not fair with Mr. Gordon.

Mr. SCRIVNER. Do you think, then, that that feeling on the part of Mr. Farrington has caused him to be biased in the report which he has made concerning your hospital?

Dr. MURPHY. Well, I would know no other reason, because, as I say, I have never had any words with Mr. Farrington, I thought we were getting along and he had not made complaints to me about these things, and I just know no other reason.

Mr. SCRIVNER. Yet, as I recall that report, it indicated that they had complaints from the patients in that hospital over a period of years.

Dr. MURPHY. Well, I think there is always some complaint. If you want to say there is no complaint from a hospital, I do not believe we have that type of hospital.

Mr. SCRIVNER. Justifiable or otherwise?

Dr. MURPHY. Certain ones are justifiable. Of course, we try to do everything we can to correct these complaints as soon as we get them, but we have to keep on our toes all the time, because somebody will slip along the line and you have to correct it; just as in any other organization, you will have a slip occasionally.

Mr. SCRIVNER. How many of the doctors on your staff are from the Army?

Dr. MURPHY. Well, there are eight of us in uniform now.

Mr. SCRIVNER. No; I mean assigned to you from the Army.

Dr. MURPHY. One man. He has been sick—he was there about a month and a half and he has been sick since the 21st of February; in fact, he has not been around there for about 3 months now, I believe.

Mr. SCRIVNER. Well, that sickness among these men that are assigned by the Army seems to be chronic; this is the second or third hospital that has made the same report.

Dr. MURPHY. I could not say "Yes" or "No" because I only know of this case.

Mr. SCRIVNER. What was his attitude toward the Service Veterans' Administration?

Dr. MURPHY. He was very much against it there. He had never done any work in tuberculosis, and he was very much against it, and in fact asked to be relieved from the assignment to a general hospital. He preferred to be near his home, but that was not done by the central officer here and, of course, I had no action to take in the matter. I merely sent the letter in as he requested and that was as far as I could go on it.

Mr. SCRIVNER. The reason I asked that particular question about his attitude was to see whether or not that attitude was prevalent

throughout the veterans' hospitals on the part of the men assigned to them by the United States Army, and the question was prompted by a letter which I have just received reporting on an Army doctor that was assigned to Wadsworth after having been at Siam, who almost, it seems apparent, practically every day damns the Veterans' Administration and the Army too, and expressed the fact that he has not any use for the veteran that finds it necessary to enter a veteran's hospital and goes further and says: "They are all nuts for being there," and that they just "enter the damn place to get out of work and cause people to pay more taxes."

Dr. MURPHY. Well, of course, I could not agree with that statement because we have sick men who need treatment in our hospital.

Mr. SCRIVNER. Well, is it not true of practically every man that enters a veterans' hospital?

Dr. MURPHY. It has been my experience; yes.

Mr. SCRIVNER. Of course, this was not the same man you were talking about who was assigned to you but that was his attitude, something similar to that which I have just expressed here?

Dr. MURPHY. He did not care about the work at all, was not interested, had not done any work in that line, and did not care to learn.

Mr. SCRIVNER. Of course, if that is the attitude of these men, then certainly we are not losing much in view of the Army's order that they were not going to assign any more of them to the veterans' hospitals. Well, I expect you had better not answer that. I can make those statements and you cannot. But, at any rate, it does not paint a very pretty picture as far as the veterans in the hospitals are concerned with doctors there to serve them, expressing the attitude almost of contempt for those patients.

Dr. MURPHY. It would surely be very much against the ex-service-man to have a man in the service of that type, who would show that attitude toward the patient, and express such feelings toward them.

Mr. SCRIVNER. That is all, Mr. Chairman.

The CHAIRMAN. Mrs. Rogers?

Mrs. ROGERS. Colonel, of course, if we had had a Medical Corps this situation would never have arisen, and you would not have had to have the Army doctors transferred. The Army, I understand, was very unwilling to transfer the doctors to the Veterans' Administration in the beginning.

The CHAIRMAN. He said he just had one.

Mrs. ROGERS. I know, but I think 400 of them were transferred. Am I correct in that, Colonel?

Dr. MURPHY. I would not know.

Mrs. ROGERS. I think, Mr. Chairman, it is very helpful to take that up with us, is that not true?

The CHAIRMAN. Well, we are not investigating the Army.

Mrs. ROGERS. But he transfers the men and the Veterans' Administration tells me they need these 400 men very much, indeed, in the next few weeks. I see General Bradley has asked us to wait about legislation until his return. In the meantime, the men are going to need some kind of doctor's care. You have only one Army doctor in your hospital.

Dr. MURPHY. No; one that was assigned from the Army.

Mrs. ROGERS. Yes.

Dr. MURPHY. Yes. We have a number in uniform that were in the Veterans' Administration prior.

Mrs. ROGERS. Yes; but I mean——

Dr. MURPHY. That is correct.

Mrs. ROGERS. But assigned from the Army?

Dr. MURPHY. That is right.

Mrs. ROGERS. Have you any suggestion as to how the lack of doctors can be taken care of for the present, until General Bradley returns?

Dr. MURPHY. That is a very difficult question to answer right today, because doctors are very, very scarce all over the country; even the private hospitals are almost without doctors, some of them, and to find those doctors, until they are released from the Army or Navy, is going to be very, very difficult.

Mrs. ROGERS. Well, I should think real suffering would ensue as a result.

Dr. MURPHY. Well, it is true that we will have to spread them fairly thin for a while, and do our very best to care for the ex-serviceman until we can get relief from some source.

Mrs. ROGERS. Do you have any mentally ill patients who are also TB cases?

Dr. MURPHY. No; we have none. We do not keep them at our institution. We are not equipped to keep that type of patient.

Mrs. ROGERS. Where did they go?

Dr. MURPHY. Palo Alto have some beds there.

Mrs. ROGERS. For the NP, TB cases?

Dr. MURPHY. That is correct.

Mrs. ROGERS. Were you here when Dr. Lorenz testified regarding the beatings in State hospitals?

Dr. MURPHY. No; I was not here this morning.

Mrs. ROGERS. It is a very shocking condition and I think the whole public ought to take cognizance of that.

Dr. MURPHY. Well, if there are beatings, of course——

Mrs. ROGERS. And the Public Health Service should make arrangements to get the type of attendants, even if it requires a good deal higher pay in order to see that mental cases are properly cared for. You agree that it is the responsibility of this committee to see that you get the proper attendants?

Dr. MURPHY. Yes; I would not be for the abuse of any patient and especially any mental patient who is helpless. I admit they get hurt at times; they hurt each other. I have been in mental hospitals. In fact, I was in neuropsychiatric work for some time, and you have injuries among those cases regardless of who you have for attendants, because if nothing else, they will hit each other.

Mrs. ROGERS. And they are very quick?

Dr. MURPHY. Very quick.

Mrs. ROGERS. And very strong?

Dr. MURPHY. And act on the spur of the moment before they can be stopped.

Mrs. ROGERS. Have you a shortage of nurses?

Dr. MURPHY. Yes, we have; a very acute shortage of nurses; in fact, we have a number of beds that we have not opened for that reason.

Mrs. ROGERS. How many?



Dr. MURPHY. We have about 75 beds we would have opened if we had had nurses.

Mrs. ROGERS. Is that true of orderlies and attendants?

Dr. MURPHY. Well, we have been furnished with 130 limited-service men, for the attendant group: that is hospital and mess attendant group.

Mrs. ROGERS. Are they physically able to perform their duties?

Dr. MURPHY. Some of them are physically fit; others are handicapped in different ways, and have numerous complaints.

Mrs. ROGERS. They have been satisfactory, though, in the main?

Dr. MURPHY. We have got along with them. They have not been what we would like, they have not been up to the old standard of our attendants we have previously had, because they are not trained men. Nobody is to blame for it. The Army did not have the trained men to send us, we are sure of that, and we took what they sent us. We had to. And they have not been entirely satisfactory. No, I cannot say they have, and I would not say you would get nearly the work out of them that you do one of our hospital attendants of the civil-service group.

Mrs. ROGERS. Are you short in doctors?

Dr. MURPHY. We have one vacancy in doctors except the one that has been sick since February.

Mrs. ROGERS. Do you find the local community cooperative?

Dr. MURPHY. Well, just what would you mean by that?

Mrs. ROGERS. Well, do you find them helpful in sending things to the hospital, taking the men to ride, and providing entertainment for them?

Dr. MURPHY. Well, with the gasoline condition today, no; I would say they do not, because they do not have enough gasoline to hardly get out there. The Red Cross come out and the Gray Ladies in cars furnished the Red Cross, but—

Mrs. ROGERS. I ask that because in some communities I find the minute a man takes off his uniform and goes into a veterans' hospital, the entertainment or the fine entertainment stops for the veteran.

Dr. MURPHY. No; I would not say it stops with us. We have what I think is very good entertainment, and that is especially true of our AMP group.

The CHAIRMAN. Doctor, you were summoned here because these charges have been made, and I think that counsel ought to read those charges to you and let you answer those first, and then get on these general questions. If that is satisfactory to the committee, I think perhaps that is the way it should be done.

Mrs. ROGERS. That is all right with me. I was late coming in, and I thought they might have been answered.

The CHAIRMAN. That is all right.

Mr. McQUEEN. Doctor, under this series of questions, again, which was sent out, question 2 is:

Has any remedial action been taken by the Veterans' Administration in these cases or others which may have been previously reported?

The answer to that question is:

To my knowledge, no action has been taken by the Veterans' Administration to take any remedial action on complaints that have been sent in in the past.

Now, let me ask you this: If there is any complaint about your hospital, what procedure would it go through whereby you would know or not know about it? Do you know what procedure is gone through? Does the complaint go into the central office of your hospital?

Dr. MURPHY. If it came into the central office they would come back and ask me about it. They do on other things, and I am sure they would on those.

Mr. McQUEEN. Have there been any complaints made by anyone in the last, we will say, 2 years, whereby that has been forwarded to you for answer?

Dr. MURPHY. Well, not that I recall; but I will tell you of the one that Mr. Mulcare brought to my attention.

Mr. McQUEEN. Is that the only complaint you have had?

Dr. MURPHY. That is the only one that came to my attention.

Mr. McQUEEN. In how long?

Dr. MURPHY. I have been there almost 2 years.

Mr. McQUEEN. Almost 2 years?

Dr. MURPHY. Yes.

Mr. McQUEEN. What was the nature of that complaint?

Dr. MURPHY. That they were not getting enough fresh fruit.

Mr. McQUEEN. Was that matter remedied?

Dr. MURPHY. So far as we could remedy it. Fresh fruits and vegetables are not nearly as plentiful in that area as they were one day; that is true throughout that area, because the Japanese were the people that cared for the fruit and vegetables in that area, and they are not there today, as you people know.

Mr. McQUEEN. Well, through whom did that complaint come—the American Legion, the VFW, DAV—do you know?

Dr. MURPHY. Mr. Mulcare.

Mr. McQUEEN. Who is he?

Mr. KRAABEL. Mr. Mulcare is regular field serviceman, American Legion.

Mr. McQUEEN. Now, Doctor, that one complaint was taken up with you and has been remedied, so far as you know, or as far as it could be?

Dr. MURPHY. I feel it has been; yes.

Mr. McQUEEN. Now, in this first question, when they talk about numerous complaints, has there been any other complaint forwarded to you during the 2-year period in which you have been there?

Dr. MURPHY. Well, the patients themselves have taken up the radio problem with the management there on several occasions. They feel that a one-way radio set-up does not give them what they would like in choice of programs, and that in turn has been taken up with the central office, and we have had the reply that they are not able to do anything at this time; they expect to put in a three-way channel as soon as the material and all are available.

Mr. McQUEEN. Well, that equipment is all furnished by the central office?

Dr. MURPHY. By the central office, and it must be approved by them, of course.

Mr. McQUEEN. And you have an antiquated system in there now, or do you have a modern system?

Dr. MURPHY. No, I would not say it is antiquated, but you can only get one station. They would like a three-way set-up so you could have your switch so you could turn to one of three stations rather than just have the one and take the same program that they all take. And of course you cannot please 315 men. In fact, two people are pretty hard to please.

Mr. McQUEEN. All right. Now, let us go over to question No. 8:

What definite complaints, if any, are there as to the quality, quantity, variety, and preparation of food in the veterans' hospital?

The answer to that question on this report is:

Every patient I talked to complained about the food not being suitable for sick patients. There was no salad on the noon meal, and one of the boys that works in the kitchen told me that very few patients ate the night meal at all, and most of it goes into the garbage. Also many of the patients complain about dirty dishes.

Now, how many complaints, or what complaints have you had out there in regard to food?

Dr. MURPHY. Well, we have complaints from the patients that we do not have enough steaks, but I tell them they have not been able to get the steaks yet; we have not been able to get the variety of meats that we formerly were able to get, and that is especially true of fowl. Fowl has been very hard to get. Veal has been very hard to get. In fact, we have been able to get almost no veal. Certain pork products have not been too plentiful through the area. We have always been able to get plenty of beef. We have never had a time when we could not get beef.

The CHAIRMAN. Beef?

Dr. MURPHY. Yes, sir. We could always get beef.

Mr. HUBER. How often do you have steak?

Dr. MURPHY. I would say on an average of once a week. We probably have Swiss steak so as to have it twice a week, but I am talking about broiled. We have Swiss steak in there.

The CHAIRMAN. Do you have a menu, Doctor?

Dr. MURPHY. Yes, sir, I have.

Mr. McQUEEN. Have you got your menu there for the week of around the——

Dr. MURPHY. I do not believe I have that one, because I know what you are going to ask; April 4?

Mr. McQUEEN. I would like to have the one for the week of April 4 or 5.

Dr. MURPHY. I do not have that one. I believe I have it here. I was afraid I did not have it.

Mr. McQUEEN. What date is this now?

Dr. MURPHY. April 2.

Mr. McQUEEN. All right.

Dr. MURPHY. Do you want all three meals?

Mr. McQUEEN. Yes; give the meals on April 2. What was April 2?

Dr. MURPHY. Monday.

Mr. McQUEEN. What meals did you actually serve on April 2?

Dr. MURPHY. For breakfast, they had grapefruit, scrambled eggs, Wheatena or dry cereal, toast and butter, coffee or milk. That was the breakfast meal.

The dinner was pot roast and gravy, parsley potatoes, mashed rutabagas, bread and butter, grape jelly, steamed pudding, sauce, coffee, tea, or milk.



For the supper——

The CHAIRMAN. That is the noonday meal?

Dr. MURPHY. Yes; that is what we call our dinner, sir.

The CHAIRMAN. Yes.

Dr. MURPHY. Supper was cream of corn soup, Italian spaghetti with grated Parmesan cheese, buttered cauliflower, bran muffins, butter, fruit salad, milk or tea.

Mr. McQUEEN. What do you have on the following day?

Dr. MURPHY. On April 3, for breakfast: Stewed prunes, fried eggs, Cream of Wheat or dry cereal, toast and butter, coffee, milk.

For dinner: Braised beef with vegetables, dumplings, green salad, bread and butter, apricot upside down cake, and coffee, tea, or milk.

For supper: Puree of bean soup, cold meats and cheese, potato salad, fresh spinach, bread and butter, milk or tea, pears for dessert.

Mr. McQUEEN. Now, read the last one on there. Skip down to the last one.

Dr. MURPHY. On April 8, which was a Sunday, for breakfast: Pine-apple juice, soft-cooked eggs, Cream of Wheat, toast, butter, coffee or milk.

For dinner: Roast lamb with gravy (mint sauce), browned potatoes, fresh frozen peas, pickles, hot buns, butter, butterscotch sundae, coffee, tea, or milk.

Supper: Corn chowder, tuna fish salad, lyonnaise potatoes, pickled beets, bread and butter, baked apple, milk or tea.

Mr. McQUEEN. Now, can we have that to place in the record?

Dr. MURPHY. Well, we would have to have you copy that. That is central office's copy. [Reading:]

#### WEDNESDAY, APRIL 4, 1945

Breakfast: White figs, soft-cooked eggs, rolled oats or dry cereal, toast and butter, coffee or milk.

Dinner: Boiled New England dinner (boiled beef), boiled potatoes, buttered turnips-carrots, dill pickles, bread and butter, ice cream, coffee, tea, or milk.

Supper: Vegetable soup, hamburgers with gravy, hashed browned potatoes, sliced onions, hot buns and butter, raw apples, milk or tea.

#### THURSDAY, APRIL 5, 1945

Breakfast: Grapefruit, hot cakes with sirup, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Breaded pork chops with gravy, mashed potatoes, scalloped tomatoes, bread and butter, apple pie with cheese, coffee, tea, or milk.

Supper: Cream of potato soup, chile con carne, green salad, bread and butter, cookies and fruit (prunes, plums), milk or tea.

#### FRIDAY, APRIL 6, 1945

Breakfast: Stewed apricots, scrambled eggs, Wheatena or dry cereal, toast and butter, coffee or milk.

Dinner: Puree pea soup, baked fish with tartar sauce or hash, browned potatoes, cabbage salad, bread and butter, apricot sundae, coffee, tea, or milk.

Supper: Barley broth, baked macaroni with cheese and tomato sauce, buttered string beans, pineapple and cottage cheese salad, bread and butter, spice cake, milk or tea.

#### SATURDAY, APRIL 7, 1945

Breakfast: Rhubarb, bacon and eggs, rolled oats or dry cereal, toast and butter, coffee or milk.

Dinner: Hamburgers with onion sauce, parsley potatoes, chilled tomatoes, bread and butter, cottage pudding with chocolate sauce, coffee, tea, or milk.

Supper: Cream of vegetable soup, meat pie, lettuce salad, rye and white bread and butter, fruit jello and cream, milk or tea.

## MONDAY, APRIL 9, 1945

Breakfast: Orange, fried eggs, rolled oats or dry cereal, toast and butter, coffee or milk.

Dinner: Roast lamb with gravy (mint sauce), mashed potatoes, broccoli with lemon, bread and butter, grape jelly, pumpkin pie, coffee, tea or milk.

Supper: Vermicelli soup, frankfurters with mustard, sauerkraut, string beans, bread and butter, fruit cup and cookies, milk or tea.

## TUESDAY, APRIL 10, 1945

Breakfast: Prunes, soft-cooked eggs, Wheatena or dry cereal, toast and butter, coffee or milk.

Dinner: Corned beef with relish, parsley potatoes, cabbage in cream, pickled beets, bread and butter, apple Betty with custard sauce, coffee, tea, or milk.

Supper: Cream of asparagus soup, hamburgers, diced buttered potatoes, sliced onions, hot buns and butter, graham crackers and fruit (peaches), milk or tea.

## WEDNESDAY, APRIL 11, 1945

Breakfast: Bananas, hot cakes and sirup, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Swiss steak with gravy, mashed potatoes, lettuce with thousand island dressing, bread and butter, hot gingerbread with hard sauce, coffee, tea, or milk.

Supper: Split-pea soup, cold salmon with lemon, cream cheese, potato chips, rye bread and butter, cinnamon rolls, coffee, tea, or milk.

## THURSDAY, APRIL 12, 1945

Breakfast: White figs, bacon and fried egg (1), rolled oats or dry cereal, toast and butter, coffee or milk.

Dinner: Breaded pork chops with gravy, parsley potatoes, buttered corn, hot rolls and butter, peach pie with cheese, coffee, tea, or milk.

Supper: Barley broth, lamb stew, noodles, pineapple and cottage cheese salad, bread and butter, cottage pudding with lemon sauce, milk or tea.

## FRIDAY, APRIL 13, 1945

Breakfast: Grapefruit, scrambled eggs, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Cream of tomato soup, grilled fish with tartar sauce or hash, mashed potatoes, cabbage and green pepper salad, bread and butter, Vanilla ice cream, coffee, tea, or milk.

Supper: Vegetable soup, baked pork and beans, hot bran muffins with butter, lettuce and deviled-egg salad, bread and butter, fruit gelatin and cream, milk or tea.

## SATURDAY, APRIL 14, 1945

Breakfast: Stewed fruit, fried eggs, Wheatena or dry cereal, toast and butter, coffee or milk.

Dinner: Broiled liver and bacon, parsley potatoes, glazed onions, bread and butter, upside-down cake, coffee, tea, or milk.

Supper: Puree bean soup, meat loaf with tomato sauce, diced buttered potatoes, apple-date and carrot salad, raisin and white bread and butter, baked custard, milk or tea.

## SUNDAY, APRIL 15, 1945

Breakfast: Oranges, soft-cooked eggs, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Roast prime ribs with gravy, mashed potatoes, fresh frozen lima beans, hot rolls and butter, butterscotch sundae, coffee, tea, or milk.

Supper: Cream of corn soup, cold meat and sliced cheese, potato salad, buttered asparagus, bread and butter, ice-box cookies and fruit (cherries), milk or tea.

## MONDAY, APRIL 16, 1945

Breakfast: Canned grapefruit, scrambled eggs, rolled oats and dry cereal, toast and butter, coffee or milk.

Dinner: Fried ham with country gravy, parsley potatoes, cabbage and pineapple salad, bread and butter and jelly, Norwegian prune pudding with cream, coffee, tea, or milk.

Supper: Vegetable soup, Italian spaghetti with grated cheese, buttered green lima beans, sweet pickles, bread and butter, fruit salad and graham crackers, milk or tea.

## TUESDAY, APRIL 17, 1945

Breakfast: Pineapple juice, soft cooked eggs, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Meat pie, browned potatoes, mashed rutabagas, bread and butter, steamed pudding with foamy sauce, coffee, tea, or milk.

Supper: Cream of tomato soup, frankfurters and kraut, fresh spinach, rye bread and butter, date and graham cracker, custard pudding, milk or tea.

## WEDNESDAY, APRIL 18, 1945

Breakfast: Grapefruit, hot cakes and sirup (dining rooms), soft-cooked eggs (trays), rolled oats or dry cereal, toast and butter, coffee or milk.

Dinner: Pot roast with gravy, buttered noodles, green salad, hot biscuits and butter, strawberry jam, ice cream, coffee, tea, or milk.

Supper: Julienne soup, little pig sausages, lyonnaise potatoes, string beans, raisin bread and butter, fruit and cookies (raw apple), milk or tea.

## THURSDAY, APRIL 19, 1945

Breakfast: White figs, Wheatena or dry cereal, fried eggs, toast and butter, coffee or milk.

Dinner: Roast lamb with gravy (chops for dining room), mashed potatoes, buttered peas, bread and butter, fruit gelatin and cream, coffee, tea, or milk.

Supper: Barley broth, meat loaf, with tomato sauce, buttered potatoes, pear-apricot and cottage cheese salad, cinnamon rolls, milk or tea (coffee for mess hall).

## FRIDAY, APRIL 20, 1945

Breakfast: Stewed prunes, scrambled eggs, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Purée of split pea soup, baked fish with tartar sauce or hash, browned potatoes, lettuce and tomato salad, bread and butter, pineapple sundae, coffee, tea or milk.

Supper: Vegetable soup, cold meat and sliced cheese, baked potatoes, pickled beet and deviled egg salad, bread and butter, devil's food cake, milk or tea.

## SATURDAY, APRIL 21, 1945

Breakfast: Oranges, rolled oats or dry cereal, fried eggs, toast and butter, coffee or milk.

Dinner: Grilled hamburgers with sliced onion, mashed potatoes, buttered cabbage, bread and butter, apple pie, coffee, tea, or milk.

Supper: Potato soup, boiled navy beans with pork, Boston brown bread, carrot salad, bread and butter, fruit (apricots), milk or tea.

## SUNDAY, APRIL 22, 1945

Breakfast: Tomato juice, soft cooked eggs, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Swiss steaks with gravy, parsley potatoes, fresh frozen buttered peas, hot rolls and butter, celery hearts and pickles, peach sundae, coffee, tea, or milk.

Supper: Cream of tomato soup, cold salmon with lemon, potato salad, string beans with bacon, bread and butter, cookies and fruit rubarb sauce, milk or tea.

## MONDAY, APRIL 23, 1945

Breakfast: Stewed prunes, scrambled eggs, Wheatena or dry cereal, toast and butter, coffee or milk.

Dinner: Meat loaf with gravy, mashed potatoes, broccoli, bread and butter, bread pudding with raisin sauce, coffee, tea, or milk.

Supper: Purée of bean soup, pork link sausage with gravy, steamed potatoes, buttered carrots, bread and butter (rye and white), raw apples, milk or tea.

## TUESDAY, APRIL 24, 1945

Breakfast: Grapefruit, fried eggs, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Swiss steak with gravy, French fried potatoes, buttered cauliflower, bread and butter, steamed pudding with sauce, coffee, tea, or milk.

Supper: Vegetable soup, salmon and noodle casserole, string beans, artichoke with mayonnaise, bread and butter, coffee and cake, milk or tea.



## WEDNESDAY, APRIL 25, 1945

Breakfast: Bananas, soft-cooked eggs, rolled oats or dry cereal, toast and butter, coffee and milk.

Dinner: Beef stew with dumplings, parsley potatoes, cabbage salad, bread and butter, ice cream, coffee, tea, or milk.

Supper: Purée of pea soup, French toast and jam, bacon, grated carrot salad, bread and butter, graham cracker cake with chocolate icing, milk or tea.

## THURSDAY, APRIL 26, 1945

Breakfast: Stewed apricots, hot cakes with sirup (dining rooms); soft-cooked eggs (wards), Cream of Wheat or dry cereal, coffee or milk, toast and butter.

Dinner: Hamburgers with gravy, steamed potatoes, glazed onions, hot buns with butter, peach pie, coffee, tea, or milk.

Supper: Beef-vegetable soup, macaroni and cheese, green lima beans, spring salad, bran muffins, fruit, milk, or tea.

## FRIDAY, APRIL 27, 1945

Breakfast: Applesauce, scrambled eggs, Wheatena or dry cereals, toast and butter, coffee or milk.

Dinner: Cream of vegetable soup, fried fish with lemon or hash, new potatoes (in jackets), buttered peas, bread and butter, ice cream, coffee, tea, or milk.

Supper: Vermicelli soup, sardines and hard-boiled eggs, scalloped potatoes, pineapple and cottage-cheese salad, bread and butter, peanut-butter cookies, milk or tea.

## SATURDAY, APRIL 28, 1945

Breakfast: White figs, fried eggs, rolled oats or dry cereal, toast and butter, coffee or milk.

Dinner: Pork chops and gravy, dressing, parsley potatoes, cabbage salad with cream dressing, bread and butter, fruit gelatine with custard sauce, coffee, tea, or milk.

Supper: Cream of corn soup, chef's salad (shrimp-egg-lettuce), sliced tomatoes, buttered string beans, bread and butter, graham crackers and fruit, milk or tea.

## SUNDAY, APRIL 29, 1945

Breakfast: Grapefruit, soft-cooked eggs, Cream of Wheat or dry cereal, toast and butter, coffee or milk.

Dinner: Pickles and carrot sticks, baked ham with apple butter, sweetpotatoes, fresh asparagus, hot rolls and butter, ice cream, coffee, tea, or milk.

Supper: Vegetable soup, stuffed peppers with tomato sauce, potato salad, Harvard beets, nut bread and butter, fruit, milk, or tea.

Mrs. ROGERS. May I ask a question at this point?

The CHAIRMAN. Yes.

Mrs. ROGERS. Do you allow the patients all the milk that they want?

Mr. MURPHY. There is no limit, with their meals they can have all the milk they want, one or two or three glasses. We do not restrict them on that. We think milk is a good diet.

The CHAIRMAN. Well, I wish the investigator who complained of that menu could go over in the House Restaurant and take a meal about this time of day.

Mr. SCRIVNER. I did not understand the investigator complained. I understood it was the veterans in the hospital who complained to him.

The CHAIRMAN. He is the one who said the veterans complained to him.

Mr. SCRIVNER. Well, that is not many complaining.

Mr. HUBER. If he were to eat in the House restaurant a few days he might be glad to get back.

Mrs. ROGERS. I suppose it might be the way the food is prepared also.

Mr. ENGLE. There is a lot of difference between making a menu and making a dinner, too. You can have a good paper menu and it might not be so good when it is prepared.

The CHAIRMAN. Yes; and you were not here to hear the beginning of this. The man in this fellow's office was turned out of this hospital because his work was not satisfactory.

Mr. SCRIVNER. That was not it at all.

The CHAIRMAN. That is what he said.

Mr. SCRIVNER. No; this was another man entirely, Mr. Chairman, who was sent there as a contact officer who was a friend of the man who made the report.

The CHAIRMAN. Well, he is down there with them now, is he not?

Dr. MURPHY. Not with us.

The CHAIRMAN. Where is he now?

Dr. MURPHY. This man that was released?

The CHAIRMAN. Yes.

Dr. MURPHY. The last I knew of the man he was in the adjutant's office in San Francisco.

The CHAIRMAN. Well, I thought he was in the office of this man who made the report.

Dr. MURPHY. No. He is not in Mr. Farrington's office unless he has been moved.

Mr. SCRIVNER. The VFW, if I recall correctly, had an adverse report on this hospital.

Mr. McQUEEN. I have not gotten to that.

Mr. ENGLE. They both had an adverse report.

Mr. McQUEEN. Now, let me ask you, Doctor, do you check the menus at your hospital carefully each day?

Dr. MURPHY. I check them before they are even printed; before it is signed, I check it and look it over, and quite often I call the dietitian and if she has two meals that do not look too good on the same day, say a dinner or supper, I ask her to substitute a better meal one of those times. Of course, I suppose that is a matter of my taste, because if I do not think it looks like it might be too appetizing for the patients, I ask them to change it.

Mr. McQUEEN. In how many instances do they substitute on these menus that are filed each week?

Dr. MURPHY. Very little.

Mr. McQUEEN. Well—

Dr. MURPHY. You will see probably a few corrections there where they have substituted, but I would say—it might be two articles a week or maybe more—but I would say two or three articles a week would be all that would be changed. It might be in the salad or it might be in the meat. We make up the menu and sometimes are not able to get the meat that we expected to get.

Mr. McQUEEN. How much service has the dietitian had, that is there now, with you?

Dr. MURPHY. You mean how long has she been in the service?

Mr. McQUEEN. Yes.

Dr. MURPHY. Many years, I cannot tell you just what, about 20, I believe.

Mr. McQUEEN. Was she there when you took charge?

Dr. MURPHY. Yes; she was there when I arrived. She has been there about 4 years.

Mr. McQUEEN. Have you ever had any trouble with her in any way in the preparation of the meals or has she complained to you about what you furnished her, or what the hospital furnished her to put on her menus?

Dr. MURPHY. I cannot recall that she has complained that we have not furnished her sufficient food. She requests, on her own, what vegetables and what meats and what fruits she wants and that goes through the supply, and goes over my desk, is approved, and if they can get it, it is bought, but today we do not always get everything she requests, because we cannot find it. It is not easy all the time, even with the fruit and vegetables.

Mr. McQUEEN. How many of your patients are ambulatory patients out there?

Dr. MURPHY. Well, about one-third of them, I would say. It changes, of course, some, but about a third of them could be considered as ambulatory.

Mr. McQUEEN. Is this menu served to the patients that are in bed, that you have just read?

Dr. MURPHY. Yes; unless they are put on a special diet. Now, if a doctor sees fit to request a special diet for his patient, for some reason, he may have a tuberculous throat, or a condition of the gastrointestinal tract, which will call for a different diet, or he may have a temperature that he cannot take the regular diet, and then he can request a special diet.

Mr. McQUEEN. Any changes after these menus are sent to the central office, from which you have read, any changes that are actually made on the meal are changed on this menu?

Dr. MURPHY. They are changed before they are sent in, because that is not sent in until after the end of the month.

Mr. McQUEEN. Then the matters that are changed on here were the actual things that were served on those days?

Dr. MURPHY. That is correct.

Mr. McQUEEN. That is all I want to ask about this meal business.

The CHAIRMAN. Is that in the record?

Mr. McQUEEN. I will put the menu of April 2.

The CHAIRMAN. Do you have more charges?

Mr. McQUEEN. Yes; I have some more. I thought maybe Mr. Engle wanted to ask some questions at this point.

The CHAIRMAN. Well, let us finish with the charges and then let the committee ask what questions they wish to ask.

Give him an opportunity to answer the charges first, however.

Mr. McQUEEN. Question 21 reads as follows:

How do you find the discipline and the morale of the hospital personnel? What are their complaints, if any?

The answer to that question reads as follows:

I think I have already described the morale of the personnel, and I believe that if a reward was offered for anyone who would say a good word about the manager or the clinical director, there would be no takers, notwithstanding the fact that Colonel Murphy, the manager, has always been exceptionally nice to me.

Now, Doctor, have you had any trouble in your own staff out there in any way?

Dr. MURPHY. Well, as I said before, I have not always been able to grant them all the privileges they would like. We have been rather short of help and since they have been in uniform, they feel they should have more time off than we have granted them. Several of them, I would say, at least, have felt that they should have more time off than we have granted them. They feel that they should be given



time off to go and shop, and different things of that nature, and we have not granted that.

As I say, we have been rather short of help and they felt that we should give them more gasoline than we have O. K.'d for them for the reason that we felt that we had to conserve gasoline. We have done it in our facility with our facility cars. We have conserved mileage, combined trips, and so on as much as possible so as to conserve gas and tires. We do not think we have done that to the disadvantage of the beneficiaries, but we have tried to go along and do that to help in the war effort, which we have been told about from every angle that we were to conserve gasoline and tires.

Some of our doctors who are in uniform have wanted more gasoline than we have granted them.

Mr. McQUEEN. Have you had any trouble with your ward doctors and physicians and nurses?

Dr. MURPHY. I would not say it was trouble. I have, as I said before, denied these men in uniform the gasoline that they want, in that I did not feel we could grant them all the gasoline they wanted to run around all over the country.

Mr. McQUEEN. Well, let me ask you, are your personal relations with the other physicians in the hospital cordial?

Dr. MURPHY. Why, I think they are with most of them. I do not think there are many of them that they are not cordial with; there are one or two that are rather against the management.

Mr. McQUEEN. Who are they?

Dr. MURPHY. Well, Major Stern, the chief of the surgical services, has been rather against the management, apparently, since his arrival there.

Mr. McQUEEN. How long has he been there?

Dr. MURPHY. Since May of 1944.

Mr. McQUEEN. Where was he transferred from?

Dr. MURPHY. From San Fernando, Calif., to our facility.

Mr. McQUEEN. You and Major Stern have not gotten along?

Dr. MURPHY. I would not say we have not gotten along. As I say, he came in and he took his 2 days for travel up there, to which he was entitled, and the next afternoon he said he would like to have off for some reason; came to work in the morning and wanted to know if he could get off in the afternoon, and I said we did not give time off like that because we had work which should be done, and I did not grant it.

So, I am sure—and he made the remark, in my own house, when he was there, that it was the first time he had ever to eat with the watch so he could not go home. Well, we have a rule from the central office, that we take a half hour for lunch. I do it and expect others to do it, because that is a regulation, that we have 30 minutes for lunch time.

Mr. McQUEEN. He objected to that?

Dr. MURPHY. He objected to that because he made that remark in my house when he called the first time; in fact, the only time he has called.

Mr. McQUEEN. Did you have anything to do with the transfer up to your place?

Dr. MURPHY. Nothing in the world. I did not know he was coming until we had the letter from central office.

Mr. McQUEEN. How long had he been in the station that he was in prior to the time he came to your station?

Dr. MURPHY. I think about 3 years, but I could not be sure now. I cannot recall.

Mr. McQUEEN. Had he had any trouble that you know of down there?

Dr. MURPHY. Not to my knowledge.

Mr. McQUEEN. You and Dr. Stern, then, have not been very friendly since the first day he was there?

Dr. MURPHY. Well, I would not say we have been too unfriendly; I have not had any great deal of trouble with him, except that gasoline and time off, of which they feel he should have a little more.

Mr. McQUEEN. Doctor, what percentage of patients go absent against medical advice, out of your hospital?

Dr. MURPHY. I cannot give you the percentage.

Mr. McQUEEN. Well—

Dr. MURPHY. In the last 6 months we have had 77.

Mr. McQUEEN. You had 77.

Dr. MURPHY. Yes; but I do not know how many admissions we had and how many other discharges we had. That would be about the number that went a. w. o. l.

The CHAIRMAN. Are those doctors required to live on the grounds?

Dr. MURPHY. Well, we have quarters on the grounds and they live on the grounds. In fact they were very happy to live on the grounds before they were—

The CHAIRMAN. I mean, the doctors at that hospital, are they required to live on the hospital grounds?

Dr. MURPHY. Yes; I would say yes, because we have quarters. If we do not have quarters, of course, they cannot; but we have quarters for most of them.

The CHAIRMAN. You have quarters for most of them?

Dr. MURPHY. Yes, sir.

The CHAIRMAN. Most of them live on the hospital grounds?

Dr. MURPHY. That is correct?

The CHAIRMAN. That is a requirement?

Dr. MURPHY. If you have quarters, that has been a requirement; yes, sir. Those quarters were to be occupied.

The CHAIRMAN. Have you had any attempts to have that set aside?

Dr. MURPHY. No; because the doctors have not requested it. None of them has requested to move off.

The CHAIRMAN. There was one of those California hospitals where there was a great deal of demand at that time for that regulation to be relaxed so that they could live elsewhere, but I do not remember whether it was Livermore.

Dr. MURPHY. No; not Livermore, since I have been there; because the rent in that area is very high and, as I say, they were very glad to have to live on there. Maybe since they are in uniform, to one of our own men, it would add \$120 to his salary if he lived off and he told me he would not live off for any price because he did not want to travel back and forth and he is one of the men who would be getting a cut because he had been allowed \$120 more a month. That is the highest one, and none have asked to be moved off.

The CHAIRMAN. I see.

Mr. McQUEEN. What town is your hospital close to?

Dr. MURPHY. Livermore.

Mr. McQUEEN. How far is it from town?

Dr. MURPHY. Approximately 5 miles out from Livermore.

Mr. McQUEEN. How large a town is Livermore?

Dr. MURPHY. Livermore is probably 5,000 now. It was probably 3,000 before the emergency, I think.

Mr. McQUEEN. Seventy-five, you say, were a. m. a. and a. w. o. l. Is that a large percent or a small percent of the patients?

Dr. MURPHY. No; it is fairly large, I believe.

Mr. McQUEEN. How do you account for the absentees?

Dr. MURPHY. Our World War II boys—we tell them they are not too sick and they do not feel satisfied to stay in the hospital. They do not feel they need hospitalization too much and for that reason they leave. Some of them, of course, give the excuse that of the difference in pay, and some of those things.

Mr. McQUEEN. What percentage of your patients are World War II patients?

Dr. MURPHY. Approximately 50 percent.

Mr. McQUEEN. Approximately 50 percent?

Dr. MURPHY. Yes.

Mr. McQUEEN. Are all of these cases active when they come to you; active TB?

Dr. MURPHY. Well, practically all the World War II boys we are getting now are being discharged from the Army as having active tuberculosis.

I would say all of them. There might be a few who have pleurisy which has been diagnosed as tuberculosis pleurisy.

Mr. McQUEEN. Are most of your a. w. o. l.'s and your a. m. a.'s in the old group or in the new group?

Dr. MURPHY. I believe that the greater percent is among the younger group.

Mr. McQUEEN. Going back to the food situation, do you purchase on the local market there of this town of 5,000 people?

Dr. MURPHY. No, sir; we get our meat from South San Francisco, our vegetables from San Francisco or San Jose.

Mr. McQUEEN. Have you had any trouble in securing the meat which you have ordered or the vegetables which you have ordered other than substitute one vegetable for another?

Dr. MURPHY. In the delivery of them?

Mr. McQUEEN. Yes.

Dr. MURPHY. No; we have had no trouble; they are always on schedule. Once or twice they may have been off for 12 or—they come in there one morning at 5 or 6 o'clock in the morning, we met, but they got it in there to us.

Mr. McQUEEN. You buy those meats from large packers, do you?

Dr. MURPHY. Swift & Co. furnishes practically all our meat. We put out bids to the different companies, but Swift's are about the only people that bid on it. They have been handling the hospital for years and they have continued to handle it since this time and have taken good care of us, I would say, considering the difficulty of outsiders in getting meat.

Mr. McQUEEN. Have you noticed, well let me put it this way: Do you take cognizance of the morale of the patients; has there been any change in the morale of the patients since the World War II veterans came in over what is was before?



Dr. MURPHY. I believe, as I said before, they are young and some of them are not too sick, and there is probably more discontentment for that reason and they are rather slow to accept the fact that they have tuberculosis and that they have a long road ahead of them before they are cured, and for that reason, I would say that they were restless; yes.

Mr. McQUEEN. You would say that the morale is lower at this time than it was prior to the war?

Dr. MURPHY. I would not say the morale was lower, but there is a little more unrest, I would say.

Mr. McQUEEN. Well, I want to put in this question No. 16 here:

Is it felt that the discipline and the morale of the patients are satisfactory?

The answer to that question is:

The morale of the patients, in this hospital, is the lowest of any place I have ever seen in my 25 years as a Legion service officer, and I am surprised at the number of a. m. a. patients.

Now, have you noticed you are having a bigger percent of a. m. a. patients and a. w. o. l. patients than the average TB hospital?

Dr. MURPHY. I believe not. I believe the other hospitals will average about the same as ours.

Mr. McQUEEN. All over the country?

Dr. MURPHY. I believe that they are fairly similar to ours. I do not have figures on that, but it is my understanding that they are all having the same condition; that is, that there are a great number of these young men——

Mr. McQUEEN. Doctor, where were you transferred from when you went to Livermore?

Dr. MURPHY. From Alexandria, La.

Mr. McQUEEN. How long had you been on duty there?

Dr. MURPHY. Two years.

Mr. McQUEEN. And in what capacity at Louisiana?

Dr. MURPHY. Alexandria, clinical director.

Mr. McQUEEN. And you went from clinical director in Louisiana to the manager of this facility?

Dr. MURPHY. Yes, sir.

Mr. McQUEEN. There is a question in this report about X-rays. Is there any restriction, Doctor, by you or the clinical director in regard to X-rays to be taken of patients when ordered by war surgeons?

Dr. MURPHY. That is the responsibility of the clinical director to check and see if he feels these X-rays are necessary, because at one time it was the practice, which developed in some of these hospitals, to have routine X-rays every 3 months.

Well, until a short time ago, the central office discouraged very many X-rays being taken that often, unless a man's condition showed some change, and there is no objection then, if a man's physical condition, either due to elevation of temperature or change in the chest condition, or any other physical condition which might point to the fact that he was not doing very well, there is no objection to having an X-ray every week, if it can be shown as necessary by physical examination.

Mr. McQUEEN. Have you ever had occasion to stop X-rays from being taken or ordered them not to be taken after they had been requested by any ward surgeon?

Dr. MURPHY. I never have. Doctor Harrod has at times—especially one of our doctors, Dr. Martin, is very much, as I say, for routine X-rays which, as I say again, is not followed; not which is not followed any more, but we can have an X-ray as often as necessary and again I say he could have one every week or twice a day if it was shown to be necessary, if a man had a spontaneous pneumo-thorax during the day, and had one in the morning, he could still have another one during that day or two if necessary, there would be no objection.

Mr. McQUEEN. Now, have you had any complaints from your surgeon out there in regard to the equipment? Surgical instruments, Doctor?

Dr. MURPHY. Well, as I told you, Major Stern arrived there in May of 1944 and he felt that we were poorly equipped. However, Dr. McCrery, his predecessor, had been operating and Dr. Eloiser is an internationally known chest surgeon and they had operated with the instruments we had.

However, we had no objection to ordering new instruments.

Mr. McQUEEN. Have you secured those new instruments?

Dr. MURPHY. We have secured almost \$5,000 worth of equipment for the operating room. We have another 1,100 and some dollars which is pending; that is, it has been requisitioned but not furnished to us to date.

Mr. McQUEEN. When did your surgeon make the request for this new equipment?

Dr. MURPHY. I could not give you the dates. I can give you the dates of when they were ordered, but I cannot give you the dates that he requested them. He requested on a certain form we have, which is 2237, and it is approved by the clinical director and then goes to the supply service, and then back to my desk for final approval, and the equipment is ordered.

Mr. McQUEEN. Well, this equipment was not ordered, then, until June 14?

Dr. MURPHY. Well, you will see different dates on there, a lot of them; all different dates when they were ordered.

Mr. SCRIVNER. June 14 of what year?

Mr. McQUEEN. This year.

Dr. MURPHY. But you will find different dates.

Mr. McQUEEN. Oh, yes.

These were ordered then, smaller groups, as you needed them?

Dr. MURPHY. As he made out the request; that is correct.

Mr. McQUEEN. Well, then, the first order, the first request was in September 1944, then October of 1944, November of 1944, December 1944, and I guess almost every month in 1945.

Has that equipment been received?

Dr. MURPHY. That has all been received.

I was looking for the one which has not been received, which has been ordered. That tells the date it is received there, if you look at the last date.

Mr. McQUEEN. You purchased, then, \$4,800 worth of equipment on all those orders?

Dr. MURPHY. Yes.

Mr. McQUEEN. And \$1,150 on another order?

Dr. MURPHY. On a number of other orders, I would have to say.

Mr. McQUEEN. Yes.

I will introduce this in the record, Mr. Chairman. I will give the original to the witness and place the copy in the record.

The CHAIRMAN. That may be done.

(The list is as follows:)

JUNE 14, 1945.

To: The manager.

From: The supply officer.

Subject: Surgical equipment.

There is submitted herewith list of surgical equipment, indicating property voucher number, date the equipment was received, and the total cost:

Voucher No.	Article	No.	Date
75	Forceps, dressing, spring 5½ inches	2 each	Sept. 4, 1944
120	Clamps, towels, Backhaus, 5¼ inches	24 each	Sept. 13, 1944
120	Edges, Scissors for 6¾-inch scissors	12 packages	Do.
120	Forceps, hemostatic, Kelly	24 each	Do.
120	Scissors, dissecting, offset, 6¾-inch	2 each	Do.
120	Scissors, dissecting, straight, 6¾ inches	do	Do.
286	Needle holder, Masson, 10½ inches	1 each	Oct. 19, 1944
288	Rib cutter, Bethune, 13½ inches	do	Do.
289	Syringes, laryngeal, Lukers, 10 cubic centimeters	2 each	Do.
303	Needle holder, Hegar-Baumgartner, 5½ inches	do	Oct. 23, 1944
309	Bronchoscope, adult, Jackson, 8 millimeters by 40 centimeters	1 each	Oct. 25, 1944
333	Pad foam rubber for wheel stretcher	2 each	Oct. 31, 1944
361	Rongeur, Stille-Luer, straight, 9 inches	1 each	Nov. 1, 1944
403	Suction and pressure outfit	do	Nov. 11, 1944
409	Forceps, spring, dressing, 5½ inches	do	Do.
428	Holder, needle, box lock	do	Nov. 17, 1944
442	Raspatory, periosteal, Dolley	2 each	Nov. 20, 1944
442	Retractors, phrenic	do	Do.
442	Tips, suction, Willard Parker Hospital	do	Do.
453	Wheel stretcher	do	Do.
633	Stools, revolving, surgeons	4 each	Dec. 30, 1944
677	Sterilizers, instrument, electric	2 each	Jan. 9, 1945
757	Illuminators, radiograph	6 each	Jan. 30, 1945
777	do	4 each	Do.
912	Cabinet, instrument	1 each	Feb. 27, 1945
912	Cabinet, metal	do	Do.
912	Cabinet, recessed, drug	2 each	Do.
998	Sterilizer, utensil	1 each	Mar. 14, 1945
998	Sterilizer, dressing	do	Do.
1201	Sterilizer, utensil	2 each	Apr. 19, 1945
1202	Operating-room light	1 each	Do.
1296	Pneumothorax apparatus	do	May 4, 1945
1402	Holders, needle, Hegar-Mayo	2 each	May 22, 1945
	Sterilizer, water, with two 15-gallon tanks	1 each	June 13, 1945

NOTE.—Total cost of above, \$4,805.78.

The surgical equipment listed below is pending delivery on purchase orders. Dates indicate when order was placed.

Purchase order No.	Article	Number	Date
1403	Forceps, Kelly, straight, 5½ inches	24 each	June 11, 1945
1403	Forceps, Allis, tissue	12 each	Do.
1404	Forceps, lung, Collin	do	Do.
1404	Retractor, thoracoeplasty	1 each	Do.
1404	do	do	Do.
1405	Forceps, Harrington, clamp, 11½ inches	12 each	Do.
1406	Cannula, urethral	1 each	Do.
1412	Speculum, Graves, medium	do	June 12, 1945
1412	Speculum, Graves, large	do	Do.
1412	Forceps, Elliott	do	Do.
1412	Speculum, Auvar	do	Do.
45-VA-12782	Truck for oxygen cylinder	do	Feb. 24, 1945
45-VA-13859	Sterilizer, instrument, steam heated, recessed mounting, size 14 by 22 inches.	do	Apr. 17, 1945
45-VA-1567	Forceps, hemorrhoidal	12 each	Oct. 7, 1944
45-VA-1567	Forceps, tissue	2 each	Do.
45-VA-1567	Retractor, goiter	do	Do.
1354	Matson, modified pneumolysis set	1 each	May 29, 1945

NOTE.—Total cost of above, \$1,150.83.

H. M. WALKER, Supply Officer.



Mr. McQUEEN. Had you personally inspected that surgical equipment prior to the time that you got this new surgeon out there?

Dr. MURPHY. Yes, sir; I have been there and looked at the equipment a number of times when Dr. McCrary was there, during the first years I was there.

Mr. McQUEEN. You never had any complaints from Dr. McCrary about the equipment you had?

Dr. MURPHY. No, sir.

Mr. McQUEEN. Did you personally consider that equipment adequate?

Dr. MURPHY. Well, that is something you have to let your surgeon decide, because each man is a law unto himself, I guess, you would have to say, because these surgeons have different tools they have learned to work with, and they can work better with them, there is no doubt, if they are accustomed to them. If they want that instrument, you will get that instrument for them, because, as I say, they will do better work with it.

Mr. McQUEEN. And you did get all those that he requested?

Dr. MURPHY. We have not turned down any requests that he has put in, for instruments or equipment for the operating room.

Mr. McQUEEN. Mr. Chairman, that is all I have. With respect to this report, that is.

The CHAIRMAN. Mr. Engel.

Mr. ENGLE. Doctor, with reference to your surgery, have you blocked the efforts of any of the doctors to enter into the surgery ward?

Dr. MURPHY. No; our surgical suite has not been in operation since last October. We have a temporary set-up for our surgery, and I hope it is finished by now. It was almost completed when I left there last Wednesday, a week ago today.

Mr. ENGLE. Why has surgery not been in operation since last October?

Dr. MURPHY. We remodeled the whole thing. We put in new terrace on floors, where we had linoleum before, we put in new cupboards, we put in new lights, we put in new window shutters, we put in new view boxes, new autoclaves, new water still. We hope we have a new utensil sterilizer. It should have been there by about Saturday or Sunday of last week, and we have, you might say, fully equipped the operating room.

Mr. ENGLE. There has been some reference here in the testimony to a Dr. Sterns?

Dr. MURPHY. Yes.

Mr. ENGLE. Is he on duty there at the hospital now?

Dr. MURPHY. Yes.

Mr. ENGLE. When did he come on duty?

Dr. MURPHY. In May of 1944. He has been there a little more than a year.

Mr. ENGLE. And did he use the old operating set-up you had up to October of last year?

Dr. MURPHY. Yes; he used the operating room up to October of last year.

Mr. ENGLE. Did he complain about that?

Dr. MURPHY. Well, he said that he did not have the instruments that he should have to do certain operations.

Mr. ENGLE. Did he complain that he was not permitted to do the same amount of surgery he had in other places, say at San Fernando?

Dr. MURPHY. He did not complain before that time. He has since; that he could not do the surgery on account of our temporary operating room.

Mr. ENGLE. He blamed it on the temporary operating set-up and not upon the management; is that it?

Dr. MURPHY. Well, apparently from these accusations, he blamed it upon the management and the clinical director, which are not facts. As I say, our operating room has been out since October 15.

Mr. ENGLE. Has he complained because he has not been given the chance to take clinical or refresher work, or participating in the medical society activities, keeping abreast of the times?

Dr. MURPHY. Yes; he has complained. That was one of the things he said he wanted the gasoline for, to attend meetings and clinics, and we granted it for 3 months. My opinion, is, where I see him and his wife going out at certain times, and at the time the cars went out, that the gasoline was not used for that to a great extent. That is again now his statement, like many of these other things.

Mr. ENGLE. Do you make a practice of encouraging your doctors to keep abreast of the times?

Dr. MURPHY. Yes, sir. Not so long ago, a few months back, we went and talked to the ration board and they said they were perfectly willing to issue gasoline stamps if they would go in a group, for these men to attend medical meetings.

Mr. ENGLE. Are they required to do that on their own time or not?

Dr. MURPHY. Yes, they are required to do it on their own time, but, however, most of those meetings they attend are at night. The greater number of them are at night, so, of course, it is on their own time.

Mr. ENGLE. Where did you serve prior to the time you came to where you are now?

Dr. MURPHY. Alexandria, La.

Mr. ENGLE. Comparing Livermore with other hospitals, is there more or less surgery done in Livermore than at other similar hospitals?

Dr. MURPHY. Well, of course, Livermore, as I said before, is a hospital for the treatment of tuberculosis.

Mr. ENGLE. I understand that.

Dr. MURPHY. So you do not have the general surgery that you have elsewhere.

Mr. ENGLE. I understand, but you do chest surgery, do you not?

Dr. MURPHY. We do chest surgery. In fact, so far as the tuberculosis patients were concerned, in Alexandria, they do more chest surgery in Livermore than they do in Alexandria that is comparing patient for patient, we will say.

Mr. ENGLE. The reason I ask is that I got the impression from the reports I received, that they did less.

Dr. MURPHY. Well, we have a schedule of operations here, over a number of months, in fact, for a year or more, probably.

Mr. ENGLE. Schedule of what?

Dr. MURPHY. Operations that were done, or were scheduled to be done. I cannot tell you whether they were all done, because I do not have the operator's report showing they were done. But at least they were scheduled and presumably they were done. At least, most of them were done.

Mr. McQUEEN. Do you want to see this?

Mr. ENGLE. I would like to look at it.

Dr. MURPHY. May I suggest that if you do not want to put that bulky document in the record, you might count the number.

Mr. ENGLE. Do you have a trained anesthetist there?

Dr. MURPHY. We have a contract man in Livermore.

Mr. ENGLE. Do you have a duty for him, does he come out to do the work in that regard?

Dr. MURPHY. He has not been called since I have been there. There has not been a request for him. In 2 years I have been there, there has not been one request for the man to come out. We can get him. He is available, but these just have not requested it.

Mr. SCRIVNER. Do you mean by that, Doctor, that you have given no anesthetics in that hospital for operations in the 2 years you have been there?

Dr. MURPHY. Local anesthetics. There are a great many of these operations.

Mr. SCRIVNER. I thought you——

Dr. MURPHY. The surgeon gives the local anesthetics.

Mr. SCRIVNER. I am talking about general.

Dr. MURPHY. As I say, we have not had the general anesthetist out there since I have been there.

Mr. SCRIVNER. In 2 years?

Dr. MURPHY. Two years; yes, sir; that is correct. He has not been called for in that time.

Mrs. ROGERS. You have had no emergency appendix operations there? No emergency operations?

Dr. MURPHY. We have had some in the last year, but we have sent those to Shumaker.

Mrs. ROGERS. I see.

Dr. MURPHY. We have an arrangement with Shumaker—the Veterans' Administration have, I believe, 50 beds set aside at Shumaker.

Mrs. ROGERS. How far away is that?

Dr. MURPHY. Fourteen miles.

Mrs. ROGERS. Who operates that?

Dr. MURPHY. I could not tell you. It is naval, and I would not know.

Mrs. ROGERS. Is that satisfactory?

Dr. MURPHY. Yes; it has been very satisfactory, and the four patients that I can recall right now being sent over there had very good results, I would say.

Mr. ENGLE. Well, has there not been a request from Dr. Sterns and others for you to get a full-time anesthetist out there?

Dr. MURPHY. Dr. Stern has talked about that; yes. We have one man who I feel is a man that should be trained for that and he is one of these men that came in the first day of January of this year. He was a IV-F man and was accepted for limited service for the Veterans' Administration only, and he says he will stay in the Veterans' Administration only as long as the emergency lasts. I did not feel we would be justified in sending that man away for 4 months, probably, at least, for training, and if the emergency is over, he would probably get back after the emergency is over and we would lose his service for those 4 months.



The CHAIRMAN. What is his name?

Dr. MURPHY. Lieutenant Archibald.

The CHAIRMAN. Where is he from?

Dr. MURPHY. His home is, I believe, in Berkeley, Calif. Right there very close to us, about 40 miles away.

Mr. ENGLE. Can your doctors do a spinal?

Dr. MURPHY. Spinal anesthesia?

Mr. ENGLE. Yes.

Dr. MURPHY. Yes.

Mr. ENGLE. They do that without calling in this outside man?

Dr. MURPHY. Yes, in fact, in Alexandria, before I left there, we used general anesthetics very rarely. They are practically all spinal anesthetics, that is for general surgery. So you do not need a general anesthetist for much of your work. For certain work you do need one.

The CHAIRMAN. All essentially, Alexandria is a tuberculosis hospital?

Dr. MURPHY. No, it is a general, with about—I think they had 150 some beds, when I was there, set aside for the treatment of tuberculosis. There are many more beds than that now for tuberculosis.

Mr. ENGLE. I notice that these reports signed by Dr. Stern indicate that most of these were spinal or local anesthesia?

Dr. MURPHY. That is correct, most of the operations, as I say, are done that way. In fact, many surgeons do appendectomies under spinal.

Mr. ENGLE. What is a topical? I notice that is listed under anesthetics.

Dr. MURPHY. That is the injection of the novocaine in the area, apparently. Novocaine or one of the cocaine derivatives. These doctors use different ones.

Mr. ENGLE. Now, about the mechanical features there in the kitchen. The report submitted by the Veterans of Foreign Wars goes into some detail on that. It says—

for example, the report on Livermore, Calif., presents this startling description. No anesthetist is present to aid the surgeon, if he were to perform surgery, if he had the equipment, if he were given the go-ahead sign.

Now, that implies a lot of things.

First, the matter we have already discussed, then it says "If he were to perform surgery."

Dr. MURPHY. Well, he is performing surgery, as those reports show, I would say.

Mr. ENGLE. I agree with you on that. Then it says if he had the equipment and if he were given the go-ahead sign.

Dr. MURPHY. I believe this will show we have the equipment for it. As I say, we still have about \$1,100 worth that has not been delivered. But this will show we bought some equipment that he requested.

Mr. ENGLE. That started in September. The first order was in September?

Dr. MURPHY. Well, it seems that the first order was September 4, 1944; yes, I think that is correct.

Mr. ENGLE. He was there since March?

Dr. MURPHY. No, since May.

Mr. ENGLE. Since May 1944?

Dr. MURPHY. Yes.

Mr. ENGLE. And you do not have all the equipment yet?

Dr. MURPHY. No, we do not have all of it yet.

Mr. ENGLE. Do you have trouble getting equipment?

Dr. MURPHY. Very much trouble. Instruments are very difficult to get today. The Army and Navy apparently picked them up, and we are stepchildren, I suppose, because it seems we have a very difficult time. Soon after he came there, he wanted some instrument——

Mr. ENGLE. Well, I think almost everybody would agree that the Veterans' Administration ought to be on an equal basis with the Army and Navy in getting equipment.

The CHAIRMAN. Well, of course, there is this difference. The Army and Navy hospitals are having to take care of battle casualties.

Dr. MURPHY. Acute cases that must be cared for right now.

Mr. ENGLE. Yes.

The CHAIRMAN. Yes, sir.

Dr. MURPHY. We were getting along, and as I say, Dr. McCrery, Dr. Stern's predecessor, got along with our equipment. That was not ideal, and our operating room was not nearly ideal. I think we are going to have a very good set-up when we get through out there. I think we are going to have one that anybody can be proud of. I know I am very proud of it.

Mr. ENGLE. Well, there are some other items here, and perhaps you can cover these in a block as I go through them. For instance,

three ranges and one grill suffered frequent break-downs due to failure in the electric heating element. An oven with no thermometer and no replacement. Sink soldered and resoldered again and again. Ranges and cooking ovens without exhaust fans. Great amount of breakage of crockery due to carelessness and unconcern in handling by personnel. Out of one tray of dishes, some three dozen, five were dirty and deserving of washing again.

Can you tell me why it is in these reports there is reflected a constant complaint against dirty dishes?

Dr. MURPHY. I believe if you will read that above there, where it says that on account of the breakage, people were not interested, that will pretty much answer that question.

We have limited-service men, who are there very much against their will, and as anybody that is served in the Army knows, K. P. is a place they hate to be assigned to; in fact, they assign them there for punishment, and those boys do not enjoy it in the kitchen and it is very difficult to get them to cooperate. We have to watch them constantly and we try to. I believe he answered his own criticism there when he said that the broken dishes were due to carelessness.

Mr. ENGLE. Let me ask this question: Do you think you have more difficulty getting good personnel in your hospital than they do in others, which according to the rating of these people are better than the hospital at Livermore?

Dr. MURPHY. We have a very difficult job of securing personnel in our hospital, that is, hiring civilian personnel, for we are in a defense area, where wages are very high, and they do not look to our place for a position, because we do not pay defense job salaries.

Mr. ENGLE. You think, in other words, that your personnel problem is more difficult than it would be in Los Angeles or San Fernando?

Dr. MURPHY. I doubt if it is more difficult than it would be in Los Angeles. I do not know the areas, or San Fernando. I cannot say. But I know we are in a very high wage level area, and it is very difficult to secure civilian personnel.

Mr. ENGLE. What about your dishwashing equipment; is that any good?

Dr. MURPHY. Well, it is not new. It has been in there many years, and we expect to have new equipment. I can give you that story if you care, on the kitchen. It is a rather long drawn out affair.

Mr. ENGLE. As I understand, you have trying to get new kitchen and new dining-room equipment; is that right?

Dr. MURPHY. I have been trying since 1943, when we first started, December of 1943. That is about 6 months after I arrived there. We began to take it up with the central office then, and we told them we felt the need for a kitchen and mess hall. We are expecting new equipment with that, of course, because we need it.

Mr. ENGLE. Are you in the process of getting that now?

Dr. MURPHY. They inform us that there are \$80,000 to be set aside for 1946 for that remodeling.

Mr. ENGLE. You mean central headquarters have informed you of that?

Dr. MURPHY. Yes; that there has been or is \$80,000 which will be available after July 1, 1946.

Mr. ENGLE. Well now, have your troubles been with the central office of the Veterans' Administration getting this equipment because of failure to allocate funds?

Dr. MURPHY. Well, it has been that for getting that kitchen remodeled; yes, and the equipment.

Mr. ENGLE. In other words, your difficulty has not been as to surgical instruments, in actually finding the instruments, but in getting the authorization through the central office; is that correct?

Dr. MURPHY. Well now, I will say this, we have not asked for equipment. We felt this way: We knew that we should have—I say we knew—we felt that there was no way to do, only to rebuild or revamp our kitchen. It had to be done, because it is not large enough, our dining room is not large enough, with our increased bed capacity, and we did not order equipment, we do not know what size kitchen they are going to build us, we do not know what size equipment we will need or just where it will fit. That will all have to be figured on the one plan we consider.

Mr. ENGLE. And what have you been doing since 6 months after you arrived there, was talking with the central office of the Veterans' Administration about rebuilding the kitchen and dining room set-up rather than getting new equipment; is that right?

Dr. MURPHY. Well, we expect that all to go together and we have got a letter in here to that effect, that we needed new equipment and all. But we expected one of their representatives would be in there. They have been telling us for some time that nothing could be done until he arrived and so we have not requested this equipment, because, as I say, if we got all new equipment, and it did not fit, why we would then just be out of luck again.

Mr. ENGLE. I have been trying to figure out what you have been doing. You have been talking about making efforts, since 1943, to



get this straightened out, and yet you say you have not asked for equipment.

Dr. MURPHY. Yes, I have asked, but not at that time. Because I started it and told them that we needed a kitchen at first, and a mess hall. With that we expected, when they made up plans, and then authorized it, we expected to ask for equipment to fit that new building.

The CHAIRMAN. In other words, you think you would not know what kind of equipment to ask for until you knew what kind of space you would have to put it in?

Dr. MURPHY. That is right. We felt it should fit, as I say, the building. As you plan the building and plan the space, you have got to plan the equipment to fit that space.

Mr. SCRIVNER. Doctor, does that mean that these patients in that hospital are going to wait until some time after 1946 to have clean silverware and clean dishes?

Dr. MURPHY. Well, that is very near, this year, the end of July.

Mr. SCRIVNER. Well, I know. Pardon me.

Mr. ENGLE. Go ahead.

Mr. SCRIVNER. It is not in this official report, but let me ask one other question. You know William E. Barden, State director of rehabilitation for the VFW?

Dr. MURPHY. I met him there.

Mr. SCRIVNER. Have you had any trouble with him that would indicate that he was prejudiced in any way?

Dr. MURPHY. No; I never knew Mr. Barden until he walked in.

Mr. SCRIVNER. So that there is no personal relation between you and him that would cause him to color his statements in any way?

Dr. MURPHY. None to my knowledge.

Mr. SCRIVNER. You might be interested then in knowing that his statement as to the mechanical features of the hospital is "as to the mechanical features of the hospital in our opinion, stinks." Then he goes on to say that in connection with this inspection, they went through and they found dishes in there that were dirty and silverware which was supposed to be clean, upon which there was scum, and said that actually it nearly got him and he thought he had a pretty strong stomach. These patients are going to have to wait until you get a new dishwasher before those conditions are remedied.

Dr. MURPHY. No; I think we—we work on that all the time, to keep it clean, to keep the cleanliness in the hospital. Cleanliness and sanitation is one of the things you must keep up on.

Mr. SCRIVNER. Was there not that same condition, that day?

Mr. MURPHY. Well, I don't think it is too bad. We do have, as I say, people that are not trained.

Mr. SCRIVNER. Well, is there any reason to think that this representative of the VFW would exaggerate his statement when he makes a statement like that?

Dr. MURPHY. I know no reason why he would.

Mr. SCRIVNER. Well, apparently then, we can assume that what he saw there was as he has reported it.

Dr. MURPHY. Well, I cannot believe it was as bad as he reported because we do not see it, and I go around that kitchen regularly.

Mr. ENGLE. He also says:

I have personally visited this hospital many times in the past, and our service officers and post personnel have visited the hospital times without number, and

it is a picturization of human tragedy, and we verily believe that the very best is none too good for these patients.

Now, how can you answer a thing like that? What do you think about it? Is your hospital a picturization of human tragedy?

Dr. MURPHY. I do not believe that. It cannot be that bad. I think we are giving our patients good care. I think they are getting good food. We are not giving them, maybe, as high a standard of care as we did at one time on account of we do not have the number of personnel and we do not have the trained personnel. Our sick men are well cared for, and our men that are ambulant, we do not have as much nursing care for them as we had at one time, but our sick men, we put our nurses on those wards, and we take care of them, and I can say that they are well taken care of. You will have to bring out the case to show me, for me to agree with that statement at all.

I will have to see the case myself, mistreated, because we have not mistreated patients there, and they have not been neglected.

Mr. ENGLE. Have you ever inspected the dishes?

Dr. MURPHY. Yes; many times.

Mr. ENGLE. And found them clean?

Dr. MURPHY. Well, I would not say that they have all been clean. They have brought me dishes that were dirty at times, off trays, and they have brought me glasses that were dirty. Just before I left there, it was not clean. I went right over to the dietitian with it, and we take up those things right away and work on it but it is a constant job. You cannot just say, "Keep these dishes clean" and forget it. It is not done that way. You have to stay right on the job and keep right after them.

Mr. ENGLE. The thing that impresses me about this thing is this: I recognize that all of these hospitals have problems in connection with personnel, particularly in view of the high wages on the Pacific coast, and the employment difficulties they have. But relatively speaking, the hospitals suffering under the same detriments ought to be approximately under the same standard and the Livermore hospital is the only one in California on which I have had any serious complaint, and the report on the thing is unanimous, that is so far as the people who have been there are concerned.

Now, for instance, here is one:

A rule issued to the medical staff that more concern shall be given to prevent dust being found than care given the patient.

Have you ever issued a rule to the medical staff that—

More concern should be given to prevent dust being found than care given to the patient?

Dr. MURPHY. Well, I would have to say that I think, if I ever issued that rule, I would be very foolish and I have never issued it. I can deny that emphatically.

Mr. CARNAHAN. Mr. Engle, that is not in keeping with the other trend of the report, is it? If he is so careful about his dust, it does not accord with the cleanliness on the dishes.

Dr. MURPHY. I try to watch cleanliness and sanitation very much. I am very, very much interested in cleanliness and sanitation. I think I should be and I am.

Mr. CARNAHAN. Doctor, have you ever accompanied any of those people who made the investigations?

Dr. MURPHY. No, sir; I did not think we should accompany them. I thought we would give them a free hand.

Mr. CARNAHAN. What I am driving is, none of those things have ever been pointed out to your attention?

Dr. MURPHY. None of those four men, either of the VFW, or of the American Legion, came back to me and talked to me after they had gone through the hospital, and talked to the patients and personnel. They never came back to my office and discussed anything with me at all.

Mr. CARNAHAN. They never told you then they found the dirty dishes?

Dr. MURPHY. They did not tell me that. The only time I knew it was when these reports began to come back to us.

Mr. ENGLE. Here is one in response to question 15, it was stated:

The buildings and grounds are very clean and well kept; however, complaint was registered by the patient in the cottages about the dirt allowed to accumulate in the latrines.

Do you know anything about that?

Dr. MURPHY. Well, that has been one of our problems there, that we have been very, very busy with, much of the time, and we had a non-commissioned officer check those bath rooms each night after the men cleaned them, and he has reported them clean, and I have gone through there—in fact, after we heard that there were complaints that there was some dirt in there, I made inspections through those cottages several times a week, to watch those toilets and showers myself. If there was anything to be corrected, I did not fail to tell the physician on the board or the nurse that they should take steps to correct it, because I have never been afraid of my personnel yet, to tell them that they should do things for the betterment of the beneficiaries.

If I get to that point, why then, I think I would be wrong, because I am interested in the beneficiaries as much as anyone, I believe. I am one of them. I happened to be in World War I, and if I went in one of these hospitals, I would expect good treatment and I am sure I would get it.

The CHAIRMAN. These representatives of these veterans' organizations, did they ever complain to you of the condition of your hospital?

Dr. MURPHY. Did they complain to me?

Mr. ENGLE. Yes.

The CHAIRMAN. Yes.

Dr. MURPHY. No; they have not.

The CHAIRMAN. Have they ever complained to you about the condition of your hospital?

Dr. MURPHY. No; they have not. As I told you, Mr. Mulcare sent back a complaint that we had not, or that we were not serving sufficient fruit, and that was a complaint from a patient and I took it up, and answered Mr. Mulcare and—

The CHAIRMAN. But you say you have never had any complaints from the representatives of the VFW or the American Legion?

Dr. MURPHY. That is right.

Mr. SCRIVNER. Mr. Chairman, may I ask four or five questions, please?

Mr. ENGLE. Yes; proceed.



Mr. SCRIVNER. In reading this report of the Veterans of Foreign Wars, Doctor, which I assume that you have seen and read, in answer to question 3, they express the opinion that—

the type, scope, and quality of treatment in the Livermore Hospital was below that of State, county, and municipal institutions.

I am assuming now, that, as you said before, that as far as you knew, there was nothing between you and the VFW representative that would cause him to have any bias or prejudice against you or the hospital.

Dr. MURPHY. That is true. Well, that again is his opinion. I could not prove or disprove that, because I believe our treatment compared favorably with any hospital in the United States. I think we are giving very good treatment in tuberculosis.

Mr. SCRIVNER. Now, in answer to question No. 21, "viewed any" or rather "have you had any complaint by the officer, this apparently refers to the enlisted personnel, imbibing too freely?"

Dr. MURPHY. Well, that has been brought up in our staff, but it has never been proven, and I have not seen it, and nobody has made any report to me. It has been talked about, but no report, has been made.

Mr. SCRIVNER. Do you make any inquiry yourself to determine whether that was or was not true?

Dr. MURPHY. Yes; I have asked, but I have never seen it. So, I could not tell you.

Mr. SCRIVNER. Well, is there some condition that seems to exist there that breaks down the discipline of these enlisted personnel?

Dr. MURPHY. Well, I do not know that there the discipline is any different from that that is bad in the case of the average enlisted man. Of course, I have not been in contact with other enlisted men for some time, and I am not in a position to quite answer that one.

Mr. CARNAHAN. Will you yield, Mr. Scrivner?

Mr. SCRIVNER. Let me just ask one more and then I will be through. Can you tell us whether it is or is not a fact that the emergency surgery has been transferred from Livermore to Shumaker because you do not have sufficient facilities?

Dr. MURPHY. Well, that is where our abdominal surgery has been transferred to.

Mr. SCRIVNER. And that is because you do not have sufficient equipment or facilities at the hospital to do that?

Dr. MURPHY. Well, Dr. Herd, the clinical director felt it would not be in the best interests of the patients because we have, as I say, a temporary set-up. And while it is not bad at all—

Mr. SCRIVNER. What do you mean by a temporary set-up?

Dr. MURPHY. Well, we have had to use a room that was formerly for a ward, for an operating room. Our operating room, as I said, has been torn up since October 15 of last year, and is still not completed unless it has been completed in the last weeks.

Mr. SCRIVNER. Now, you said there had been some complaint by some of these doctors, that they were not getting enough time off.

Dr. MURPHY. Yes.

Mr. SCRIVNER. Those men are now officers in the United States Army assigned to the Veterans' Administration for duty are they not?

Dr. MURPHY. Yes; that is right.

Mr. SCRIVNER. Has the Army changed so much now that they are not considered to be in the Army 24 hours a day as we were 25 years ago?

Dr. MURPHY. Well, they seem to think that it has changed to that effect, that if they work more than their 8 hours, they are allowed time off. They come back Sunday morning, and make a sick call, and stay there from 8 until 10 o'clock. The following week they get 2 hours off for that time they spent at the hospitals.

Mr. SCRIVNER. Is that an Army regulation?

Dr. MURPHY. That is a Veterans' Administration regulation we have always followed, and that is our directive from General Hines or the Medical Director that we were to give these men compensatory time in lieu of overtime pay. When they are officer of the day, they get the following afternoon off, the same as the Veterans' Administration.

Mr. SCRIVNER. So the feeling has apparently developed that when they have done an 8-hour day's work, that is all?

Dr. MURPHY. That is right. In fact, they want to have extra time other than the 8 hours.

Mr. SCRIVNER. When you are that short of help, does that seem to build up the morale of either the staff or the patients?

Dr. MURPHY. I don't quite get you.

Mr. SCRIVNER. I say that attitude, that "When the whistle blows at 4:30 I am through," does that build up the morale of the patients at all?

Dr. MURPHY. Well, when I was ward physician, I stayed there until my work was done.

Mr. SCRIVNER. Well, they all ought to do that, ought they not, if they are really interested as a professional man rather than merely as job holders.

Dr. MURPHY. That is my feeling in the matter.

Mr. SCRIVNER. Well, that is your feeling as a professional man?

Dr. MURPHY. Yes, sir. If I have got a sick man, I am going to stay there until I take care of him.

Mr. SCRIVNER. Should that not be the attitude of all of them?

Dr. MURPHY. I feel it should, and if he stayed more than that, the other night, for instance, they had to stay because we had an emergency, they got time off.

Mr. SCRIVNER. Well, suppose they did not get the time off?

Dr. MURPHY. Well, I did not get it off when I was doing ward physician's work.

Mr. SCRIVNER. I know, but suppose they did not have the time off—well, let it go.

Mr. ENGLE. Are you through, Mr. Scrivner?

Mr. SCRIVNER. Yes.

Mr. ENGLE. Mr. Carnahan.

Mr. CARNAHAN. Your enlisted personnel in the Army they are not under your direction, are they?

Dr. MURPHY. They are not under us at all. In fact, they tell us we cannot give them an order to go there and speak up about a dirty spoon. We have to tell the noncommissioned officer and he tells them. That is our directive, the way it is to be handled.

Mr. ENGLE. Will you yield for just a question?

Mr. CARNAHAN. Yes.

Mr. ENGLE. I want to read something on that. Here is a statement in connection with that:

The hospital personnel might be divided into two major groups of civilian and Army employment and of the civilians into three levels of doctors, nurses, and orderlies, or attendants. The Army personnel furnish practically nobody other than orderlies are under the command of an officer, and a sergeant.

The categorical question put to one civilian doctor brought this response: "Frankly, I do not know what to say. We were called into a staff meeting by the clinical director, and the manager, and urged indirectly to think of the honor of the staff being at stake, and that no good could come from any criticism of the staff, which remarks were uttered while furtive glances were cast in all directions to see if the walls had ears. By indirection, though not by direct assertion, the question was answered by disarming questions urged upon ourselves mainly. How can you expect discipline of the Army personnel when the officer in charge imbibes too freely and when the first sergeant is under such a handicap?"

How about that?

Dr. MURPHY. That was not the instructions. I myself personally was at that meeting. I said:

If you will give me something that I can go before this officer's commanding officer, that will stand up, I will go before him. But I cannot go before him otherwise on hearsay, because it will probably mean court-martial charges, and I cannot do it unless I have got something definite.

Mr. ENGLE. There has been hearsay in other words to the effect that the commanding officer handling that Army contingent there has been imbibing too freely, is that it?

Dr. MURPHY. There has been that rumor.

Mr. ENGLE. And then when you asked for specific information on it, like so many things of that character, you could not pin it down, is that right?

Dr. MURPHY. That is true, they will not give it to me. They said they did not feel apparently like they could afford to do so.

Mr. ENGLE. Well, do you have any control at all over these Army people in the hospital?

Dr. MURPHY. Of this detachment?

Mr. ENGLE. Yes.

Dr. MURPHY. No; we have no control over them at all, except that they bring us a man and we assign him where we need him to do our work.

Mr. ENGLE. As I understand, they have one commissioned officer?

Dr. MURPHY. Two commissioned officers—a first lieutenant and a second lieutenant.

Mr. ENGLE. And a sergeant?

Dr. MURPHY. Several sergeants. I do not know how many. First sergeant and several others.

Mr. ENGLE. Who is it that was drinking too much according to the rumor?

Dr. MURPHY. Apparently it is their commanding officer.

Mr. ENGLE. In other words, the commissioned officer actually in charge?

Dr. MURPHY. Yes.

Mr. ENGLE. Well, is there not some way to get an investigation of that and get him fired out of there?



Dr. MURPHY. Well, I might tell you I have talked with the executive officer on that question, to see if they could do something. I told him, I said, "I cannot prove this, but it is rumored that he is imbibing too freely for the good of the detachment," and he said he would take that up. I talked to him a second time on it and he said he had discussed it with the commanding officer of the group—that was the colonel in charge, and they were going to do something, as soon as they could. That was my last knowledge of it.

Mr. ENGLE. Do you think that condition has reflected upon the efficiency of your hospital?

Dr. MURPHY. Well, it has not helped with the detachment we are sure of that. That does not build up, probably, the best spirit in the detachment.

Mr. CARNAHAN. What percentage of your help is Army personnel?

Dr. MURPHY. Well, we have 130 assigned there. Among our attendant group, at least two-thirds.

Mr. CARNAHAN. Two-thirds of them are Army personnel?

Dr. MURPHY. That is correct.

Mr. ENGLE. Are any of these men overseas veterans?

Dr. MURPHY. Some of them were overseas. Some of them, of course, have not been overseas.

Mr. ENGLE. Is there not a good deal of resentment against a man who has served overseas being brought back and put into a hospital and being asked to handle the affairs of an orderly in a hospital?

Dr. MURPHY. Well, they are not to happy with the assignment. I am sure of that.

Mr. ENGLE. Is that not of a general nature?

Dr. MURPHY. I would think it was; yes. Probably men would not take too kindly to it.

Mr. ENGLE. Do you know to what extent that practice is followed in other veterans' hospitals. To what extent the practice of using Army personnel is followed in other hospitals, that is?

Do you have more or less than they have in the average veterans' hospital?

Dr. MURPHY. Well, I expect, comparing our hospital with the other hospitals, that we probably have more than most of them on account of the fact that, as I said before, it is very difficult to employ civilians in that area. So we have had to call for more detachment men.

Mr. ENGLE. What they in effect do then, when you cannot hire people to do it, is just simply assign military personnel in there to do it?

Dr. MURPHY. That is our only alternative apparently.

Mr. ENGLE. And much to their dissatisfaction and much to the detriment of the hospital service, is that right?

Dr. MURPHY. Well, as I say, it has not been the best, but it has kept our beds open, which we could not have done otherwise. It has not been to our liking altogether. But we have tried to keep the hospital operating.

Mr. CARNAHAN. It does appear that you have to operate with more military personnel than the average veterans' hospital.

Dr. MURPHY. Because of the area we are in, yes.

Mr. CARNAHAN. Do you think the shift of the Japanese population has resulted in that condition?

Dr. MURPHY. Well, it has made more jobs for the civilians around there, laborers and so on, at higher salaries. A laborer gets \$1 an hour, and I believe the men in the hay this year received more than \$1 an hour. But I think they do in that area.

Mr. ENGLE. The men where?

Dr. MURPHY. The men in the hay. There is lots of hay around there that they put up.

Mr. ENGLE. In other words, the fellows out pitching hay get \$1 an hour, is that it?

Dr. MURPHY. At least a dollar an hour.

Mr. ENGLE. That is a lot better than I used to get.

Dr. MURPHY. Well, that is what it is. I would like for you to read this report of Mr. Mulcare, that was made the day that Mr. Fairington made his report, if you have no objection. I think that might be helpful.

Mr. ENGLE. Who is he?

Dr. MURPHY. Mr. Mulcare is an employee of the American Legion rehabilitation service who has been out there for many, many years. He covers a certain area. I think it is California, Oregon, or Washington. I am not sure just which State. What is his exact title?

Mr. McQUEEN. National field secretary.

Mr. MURPHY. Yes; he used to be called liaison representative. Now he is called national field secretary of the American Legion.

Mr. ENGLE. Who did he submit the report to?

Mr. McQUEEN. I presume it was a periodical report made to the American Legion.

Dr. MURPHY. Those men make those reports periodically and they send them to both the Veterans' Administration and the American Legion, I think.

Mr. ENGLE. Who is here representing the Legion to tell us what that is?

Dr. BAGGS. Mr. Kraabel here is the field service report that we have here. I am Dr. A. N. Baggs.

Mr. McQUEEN. You may read the report, Doctor.

Let me ask you this, Dr. Baggs: Was this report made simultaneously with this other report that came in on this other investigation? Or is this just a current report that comes in?

Dr. BAGGS. Apparently this is a current report, April 4, 1945, and the date that it was received was April 24, 1945, and a copy of it was sent to Mr. Kraabel, Mr. Armstrong, Mr. Sizon and right on down here, and to the field secretaries besides.

Mr. McQUEEN. Is that in the Administration?

Mr. ENGLE. Go ahead and read it into the record, Doctor. It is short, and I think it is probably to the point.

Dr. BAGGS (*reading*):

This Veterans' Administration hospital is located 5 miles from the town of Livermore, Calif., and 45 miles from San Francisco, Calif. The institution is utilized for the treatment of tuberculosis patients—male and female. There are 12 beds allocated for female patients. There are 5 general medical and surgical cases hospitalized; 3 males and 2 females.

The hospital is designated as a collapse-therapy center.

Due to reconstruction, 57 beds are out of service, which number should be ready for occupancy on May 15 of this year, but depending upon the securing or as-

signing of additional nurses. One cottage comprising 15 beds, is out of service and used to house Army personnel assigned to this station. It is expected that construction will commence on July 1 of this year on 100 additional beds which when completed will allow for a capacity of 450 patients.

There are 10 doctors assigned, including the manager and clinical director. There is one dentist, who is being transferred to an eastern hospital. There is one unfilled medical position. Eight doctors, including the manager are in Army uniform.

One hundred and sixteen men and two officers have been assigned from the Army as ward and mess attendants. The assigning of this Army personnel actually permits the operation of the hospital, due to the inability to secure sufficient civilian help in these two departments at the prevailing wage.

There are 11 nursing positions vacant and the manager has exhausted all efforts to fill these vacancies, and it is apparent that the shortage of this type of personnel will continue under existing war and local conditions.

There is a full-time contact representative assigned and working out of the Fort Miley facility. The contact representative is one of the rather recent men employed by the Veterans' Administration but does demonstrate an exceptional interest in his job. The contact service, considering the present load, appears satisfactory.

During the past 6 months, 53 patients left the hospital against medical advice and 24 absent without leave.

A number of complaints were made to me and the department service officer of northern California, who accompanied me to the hospital, in regard to the quality, quantity, variety, and serving of foods. In the complaints much emphasis was placed on the evening meal. The complaints of the patients as to the food served is apparently justified. Among other things, the patients desire more fresh fruit and vegetables, and the younger group especially want a heavier meal served in the evening. They also complain of the limiting of between-meal nourishments to other than underweight patients.

The kitchen is small and was constructed to meet the needs of about 50 percent of the present patient capacity of the hospital. The equipment is obsolete, and for a number of years, the American Legion has recommended replacement but no action has been taken up to the present time. There is an immediate need for the replacement of the following worn out equipment: Bake oven, ranges, grill, ice-cream equipment, hoods on diswashing machine.

It is recognized that kitchen help is a problem, but in view of this and the equipment factor, there is an apparent need of a survey of the dietetic department of this hospital.

Recreational activities consist of two movies each week and other forms of entertainment sponsored by the American Legion and other organizations. The recreational activities are satisfactory for the ambulant patients who can go into the recreational hall, but the 24-hour bed patient is neglected, not only at this tuberculosis hospital, but at all others, that I know of in the Veterans' Administration. It is recommended that a study and survey be made in order to provide entertainment for the 24-hour bed patients who are in physical condition to receive the same.

Occupational therapy now consists of weaving and leather work. This is not sufficient. The younger group is interested in activities, and from a standpoint of cure alone, they should be accommodated by increasing the present occupational therapy program to include commercial courses and other forms of occupational therapy.

Considering the reconstruction now in progress at this station, as well as the labor and other personnel problems, the station presents a fair appearance with the exception of the dining room and kitchen, which is unsatisfactory as to the condition of the walls and ceilings.

Mr. McQUEEN. That, Doctor, is a regular examination of the hospital by your field secretary?

Dr. BAGGS. Yes, sir; that is a routine inspection.

Mr. McQUEEN. How often are they made?

Dr. BAGGS. As a rule, twice a year, sir.

Mr. McQUEEN. And this covers almost exactly the same data as the other report?



Dr. BAGGS. The date of the visit here is August 14, or rather, it should be April 4, and date received April 24.

Mr. CARNAHAN. Apparently the kitchen situation has not been good for years, is that right?

Dr. BAGGS. This is underscored here, sir [reading]:

The kitchen is small, and was constructed to meet the needs of about 50 percent of the present patients. The equipment is obsolete and for a number of years the American Legion has recommended replacement but no action has been taken up to the present time. There is an immediate need for the replacement of the following equipment—

Mr. CARNAHAN. And the date of that report was?

Dr. BAGGS. The report of the visit was April 4, 1945, and the date it was received was April 24, 1945. This is received by the American Legion.

Mr. ENGLE. Are there any further questions? Well, Dr. Murphy, I would like to have your comment on that report, inasmuch as you asked it be introduced, especially in view of the criticisms and recommendations made.

Dr. MURPHY. His criticisms were mostly directed toward the kitchen, that is our dietetic end, which, as I brought out before, some time prior to December of 1938, the matter of rebuilding that kitchen and bringing it up to standard has been a subject of continuous discussion between the facility and central office.

Mr. ENGLE. Do you concur that that is a fair statement, the report?

Dr. MURPHY. I would say that insofar as the equipment is concerned, it is old. I can give you a letter that we wrote—I guess we got desperate after writing back and forth to central office about it, in regard to getting this kitchen really rebuilt—a letter of March 14, of this year, that was before any of these articles came out in press or anything else—I knew we needed the kitchen and I knew and felt we had to have it, and I can give you that letter, if you care to have me read it, that I wrote on that, and which I think will show that we were cognizant of the fact out there that we needed it very badly.

Mr. SCRIVNER. I think it ought to go in the record.

Mr. ENGLE. Put it in the record.

Dr. MURPHY. Do you want me to read it?

Mr. ENGLE. Yes; I would like to hear it.

Dr. MURPHY [reading]:

LIVERMORE, CALIF., March 14, 1945.

DIRECTOR OF CONSTRUCTION, VETERANS' ADMINISTRATION,

Washington 25, D. C.

DEAR SIR: With reference to the possible revision of the main kitchen and dining room at this station, which has been under consideration since December 1943, certain definite steps should be taken immediately to draw up plans and get construction under way. Not only from the standpoint of increased bed capacity but from the problem now involved of keeping some of the old equipment in running condition until new can be purchased. Until plans are drawn showing size and location of rooms, it is impossible to purchase equipment of the right size to be adaptable to the space and the needs of the station.

The refrigerating plant is in such a condition that it can be expected to break down at any time and will not run through the summer months without renewing the brine pumps, ice cans, and possible major repairs on the brine tank.

The ice-cream hardening cabinet and compressor may run through the summer months, but it is very uncertain.

The refrigerating plant and the ice-cream hardening cabinet referred to above are very essential to the station and should be increased in capacity to take care of the additional patient load. Additional refrigerating boxes will be required, which should be taken into consideration on the new plans.

The bake oven is past repair, without making an entire new unit. Metal side walls have rusted through in numerous places.

The present light-duty grill is too small for heavy-duty work, which it is required to perform and is continually out of order.

All ranges have served their usefulness. Switches and units require continuous repair.

All kitchen sinks have been repaired to the extent that repairs are being made on the repairs.

All of the above equipment was original equipment when the hospital was built and some of it was transferred to this station second-hand. Mention is made of the above equipment and its condition to point out the urgent need for its replacement, and to make replacements will depend on the type and size of building that is to be constructed.

In case our present kitchen, in building No. 1, is to be altered, definite arrangements should be made in the drawings to accommodate—library space, one room for the contact man, one room for the social worker, and a room of sufficient size, with a toilet adjoining, to accommodate relatives and friends of deceased patients, as outlined in all-station letter, dated March 5, 1945. A thorough study has been made of all available space in both buildings No. 1 and No. 2, for suitable space to accommodate visitors. There is no space available, without sacrificing at least two beds.

Due to the present urgent need of enlarging the present kitchen and dining-room facilities, it is believed advisable that additional space should be provided in the new construction to amply take care of the above-mentioned activities.

Since the station has waited nearly a year, and if there is no assurance that Captain Martin will be here in the near future, to make the survey of our needs and make recommendations for its improvement, it is suggested that Colonel Radcliffe be authorized to call at this facility to make a survey of station needs, and make drawings in detail for immediate action by central office.

All alterations and additions to main kitchen in building No. 1 should be completed before the completion of the ambulant cottages. For this to be possible work should start at the earliest possible date. Some of the kitchen equipment and refrigerating unit will require from 6 to 8 months before delivery is made.

At that point, I might add, our utility officer went to San Francisco about this time in March and checked with the people that deliver these ice-cream machines and they gave us a delivery date of not before January 1, 1946, if we put our order in at that time. That is why we are urging action so that we can get it at the earliest possible date. [Continuing:]

In summing up the situation, the present kitchen and dining-room facilities are too small for the increased bed capacity, and certain alterations and new construction are required. Since new construction is required, steps should be taken to make the enlargement of sufficient size to accommodate larger refrigerating and ice plants; additional refrigerating boxes; larger ice cream hardening cabinets, and compressor; larger room for library; one room for social worker; one room for contact man; one room of sufficient size, with toilet facilities, for relatives and visitors of patients, sufficient food-cart storage; dining-room space for nurses, personnel, and patients.

It is the desire of the station to be informed at the earliest practicable date what action is to be taken regarding kitchen alterations, so that necessary steps can be taken to purchase some of the more urgent pieces of equipment for this department.

Mr. McQUEEN. Who is that letter signed by?

Dr. MURPHY. By myself.

Mr. SCRIVNER. What was done about that?

Dr. MURPHY. Well, I believe I can tell you when we got a reply to that.

We wrote that on March 14; here is the letter we wrote later:

Reference is made to station letter, dated March 14, 1945, regarding possible revision of the kitchen and dining room and the purchase of new equipment.

To date the station has had no reply as to the intent of central office.

Since this letter of March 14, considerable trouble has been encountered with the compressor on the ice-cream freezer and hardening cabinet. An attempt was made to place a charge of ammonia in this unit and it was found that a vacuum could not be produced. It is evident that an overhaul job is necessary. The station has written the manufacturers to ascertain if necessary parts are available. If parts are available the station will attempt to keep the machine running without too much expense until such time as a new one can be purchased.

It is the desire of the station that Captain Martin, or some representative, call at this facility and make the necessary recommendations for alterations of the kitchen and dining room, so as to permit this station to order new equipment which is urgently required at this time.

Now, on the same date, I wrote that letter on the 26th, a letter came out from the Assistant Administrator telling us that Colonel Radcliffe, who is the superintendent of construction for the west coast area, was to check our needs there, and present them with the plans. Here is Colonel Tripp's letter in reply to our letter of April 26.

Reference is made to your letter of April 26, 1945, relative to alterations required in the kitchen and dining-hall building at your station and the purchase of new equipment.

Your letter of April 26, 1945, crossed the letter of the same date from the Assistant Administrator, relative to additional space in the kitchen and dining-hall building at your facility, and it is not believed further explanation is needed on this item.

The action taken by the station relative to keeping in operation the compressor on the ice-cream freezing and hardening cabinet has been noted, and it is believed that repairs to this unit will keep it in satisfactory operation pending the undertaking of alterations in this building, at which time consideration will be given to the equipment in the kitchen.

Mr. McQUEEN. Now, Mr. Chairman, here is another report, a subsequent report by the American Legion.

Dr. BAGGS. A previous one.

Mr. McQUEEN. A previous report by this same man, Mr. Mulcare. It might be interesting to note the difference and what they are doing as a matter of comparison.

Dr. BAGGS. That is a report of August 26, 1943, by the same national field secretary, and I will state that a copy of the previous report I read is indicated here to have been sent to Colonel Murphy, and a copy of this report that I am going to read was apparently sent to Dr. Charles P. Murphy, manager at that time.

This is August 26, 1943, by, as I stated before, Mr. James P. Mulcare, national field secretary [reading]:

This Veterans' Administration hospital utilized for the treatment of male and female tuberculosis patients is located 5 miles from the town of Livermore, and 45 miles from San Francisco. There are 12 general medical cases (heart) hospitalized.

The institution has a bed capacity of 365 of which 12 are designated for females. By enclosing porches and cubicles, the bed capacity will be increased by 72 which will total 437. This reconstruction is now under way. Utilizing of porches and cubicles for bed space is not the most favorable way of increasing the bed capacity but it appears to be the most advantageous at present. By reason of the construction now under way, 58 of the present bed capacity of 365, are closed.



At present, there are 236 patients hospitalized and designated as follows:

World War I.....	163
World War II.....	55
Spanish-American.....	8
Peacetime.....	8
Employees' Compensation Commission.....	2
Total.....	236
Females.....	8
General medical.....	12
Tuberculosis (male).....	216
Total.....	236

The acceptance of general medical cases was predicated on the evacuation of patients from the Fort Miley Hospital, immediately following the Pearl Harbor attack. Practically all of the heart disability cases at Fort Miley at that time were transferred to Livermore. It has been determined to accept no more general medical cases at Livermore and to operate the institution as a straight tuberculosis hospital.

Dr. Charles P. Murphy was appointed as manager on June 16, 1943, replacing Dr. Smith Mann, deceased. Dr. G. P. Harrod is clinical director.

The medical staff comprises 13 doctors, including the manager and the clinical director. There is one vacant medical position. There is one dentist assigned.

There are 44 nurses, including the chief nurse and 5 vacant and unfilled positions, all under the ceiling order for personnel. It is recommended that central office endeavor to fill these five vacant nursing positions.

There are 54 hospital attendants and 19 vacant and authorized jobs. There are 45 mess attendants and 13 vacant jobs. There are also two vacant laborers jobs.

With the increase in bed capacity from 365 to 437 additional medical, nursing, attendant, and other personnel will be required.

The quality and quantity of foods served is good. An inspection of the menus discloses a very good variety of meats, vegetables, and fruits. However, the dietetic service does suffer from the lack of mess attendants. The raw ration cost is 61 cents per patient per day and the per diem cost \$5.75. In my prior report of visit to this station, I recommended an additional dietitian and said recommendation was approved.

The clinical and surgical service is very good. The station is designated as a collapse-therapy center.

The surgical and other hospital equipment is good considering that no replacements have been made during the past 2 years. However, the X-ray machine and equipment is old and badly in need of replacement. An average of 1,000 X-ray plates are taken each month. It is recommended that a new and high speed X-ray machine be provided for the station.

Sanitation of the entire institution is good considering the lack of attendant personnel.

A contact representative from Fort Miley visits the station a part of a day each week. Considering the increase in World War II patients, this service is far from satisfactory as to time of the representative at the hospital.

Recreational activities are supervised by an aide and consist of two movies each week, card parties and shows, and other forms of entertainment provided by the American Legion, the American Legion Auxiliary and the Elks Lodge.

Occupational therapy consists of basket weaving, textiles, wood, and leather work.

Mr. ENGLE. Now, will you just comment briefly on what attraction you see, as a comparison between this report and the other?

Dr. BAGGS. My attention was attracted to this report by the difference of the comment on the food service.

Mr. ENGLE. In other words, the food service has deteriorated very definitely?

Dr. BAGGS. Judging from the two reports, and the other comments we have heard.

Mr. ENGLE. Also, I notice they mention some crowding there, taking over other space to make up bedroom space.

Dr. BAGGS. Yes, sir.

Mr. ENGLE. I notice here, Dr. Murphy, that one of the complaints made is that 21 beds were crowded into 1 room, which room was divided into 3 sections of 7 beds each. There seems to be a good deal of dissatisfaction among the patients about that. Why did you do it?

Dr. MURPHY. I cannot answer that. That is central-office procedure. In fact, it was started when I arrived there in June of 1943; the remodeling of wards 1 and 2 had already begun to make that change. The only thing I can say is they have to have beds, and they tell us that it was done to take care of an emergency. It was started before I arrived there.

Mr. SCRIVNER. Mr. Chairman, might I say, as far as I am concerned, while I am not very happy about the situation that exists there, having heard as we have, some blame certainly must attach to the manager of the hospital. But there are certainly some things as disclosed by the colonel, that quite a bit of blame must also attach to central office. That cannot all be placed on the shoulders of the manager, which I assume is a demonstration of the governmental red tape we hear so much about.

Mr. CARNAHAN. I would like to say, it appears to me that it is a condition that has existed for quite awhile. This has been over a period of several years. It looks to me as though you have a very difficult problem there, and I want to express my appreciation to the American Legion and the Veterans of Foreign Wars and the other organizations, which made the reports, and I believe that their calling attention to these things will help you, Doctor, to get them corrected.

Dr. MURPHY. I hope so.

Mr. ENGLE. Are there any further questions?

Do you have anything further to add to your testimony, Doctor?

Dr. MURPHY. I might say, as I said before, I am still very much interested in the ex-serviceman. Being one of them, I feel that I am one of the buddies, and I am surely not going to let a place run down if I can help it. The place has not been all I would like for it to have been in the last year, as I brought out before, and as I have to bring out again, because of our critical situations insofar as help is concerned in that area. I can only tell you that I am going to do my utmost so long as I am in the service to take care of ex-servicemen. When I do not feel I can take care of them, I will step down and out.

Mr. ENGLE. This committee is going to urge the central office to cooperate with you to see that that is done. As the only Congressman from California on this committee, I was very much disturbed to find so much criticism about this hospital when, generally speaking, throughout California reports were good.

Mr. McQueen, do you have anything further to add at this time?

Mr. McQUEEN. Nothing further.

Mr. ENGLE. Without objection, then, we will adjourn until tomorrow morning at 10 o'clock.

(Thereupon, at 4:30 p. m., an adjournment was taken until 10 a. m. the following day, Thursday, June 28, 1945.)

(The following was submitted for the record:)

REPORT OF CONDITIONS AT VETERANS' HOSPITAL, LIVERMORE, CALIF., APRIL 26, 1945

1. The complaints received were the general complaints of patients having little else to think about but the daily hospital routine. There were no specific complaints.

2. There was no information available as to whether remedial action had been taken by the Veterans' Administration, nor were there such cases on record, specifically, or otherwise.

3. We believe the treatment at the veterans' hospital at Livermore to be above standard of treatment as in State, county, and municipal institutions in the same area.

4. The manager of the veterans' hospital at Livermore feels that he has sufficient authority to run the hospital as efficiently as can be expected.

5. The regulations and restrictions under which the manager must function are the usual restrictions, and in no way hinder the operation of hospital routine.

6. Yes; the manager feels that he has sufficient authority and latitude to employ competent doctors, nurses, and attendants.

7. Yes; they do encourage and support, and have the encouragement and support, in research, in participating in clinical meetings, symposiums, medical lecture courses, etc.

8. The quality and variety of the food in the veterans' hospital is in many cases below standard. This is true because, first, the equipment is not new. The present kitchen is too small and outmoded, and should be enlarged with modern equipment. The kitchen was remodeled sometime ago to take care of a limited increase in the number of patients. Since that time the number of patients has increased to the point where the present facilities are not adequate to meet the demand. Secondly, the variety is naturally limited due to the war shortages. Thirdly, the preparation depends largely upon the inadequate facilities mentioned above, and is somewhat tasteless and unimaginative. Two specific complaints were received that insufficient precautions had been taken to guard the purity of the food, as evidenced by the discovery of insects in the food.

9. There have been no specific cases of abuse or neglect of patients in this hospital.

10. Inasmuch as the type of disease treated at this hospital restricts the participation of the patients in any physical recreation, the facilities are adequate.

Beds are equipped with earphones so that patients may listen to the radio. This, however, limits the program to one type for all patients and is not entirely satisfactory. Complaints have been made, and the younger patients seem to think providing individual radios would be the answer. However, we believe this arrangement would be difficult, as well as expensive, and provisions would have to be made to prevent the individual radios from annoying the nervous patients. (See appendix I.)

The American Legion presents a show a month for the patients. This, however, does not answer the question of providing movies and entertainment for the bed patients. Ward movies have been suggested by this organization, but as yet no arrangements have been made to give them.

11. The canteen service is very satisfactory and the prices reasonable. The canteen has recently been taken over by a regular drug firm, and two deliveries a day are made to the bed patients at 11 a. m. and 1 p. m.

12. From personal observance, and from patients' reports, we believe that the medical equipment and clinical arrangements are very satisfactory.

13. It is difficult to judge the proper period of hospitalization in individual cases without medical training.

14. Naturally, due to prevalent wartime conditions, there is a shortage of medical aid, and it may be that some patients are therefore forced to remain longer in the receiving wards than otherwise might be the case. There were no specific complaints.

15. The condition of cleanliness and neatness in the buildings and on the grounds is satisfactory. Employment of civilians and limited service soldiers helps to maintain this condition.

16. Due to the nature of the disease treated at this hospital the morale is not as high as that in other hospitals treating different disabilities. The discipline is very satisfactory.

17. The transportation facilities to and from the hospital are adequate. The busses leave the hospital for Livermore from 5:30 a. m. and continue with five



busses in the morning and nine busses in the afternoon, the last bus being the 11:30 p. m. The schedule basis is approximately one round trip hourly. The cost of transportation is very reasonable.

18. Contact service by the VFW is very inadequate and very unsatisfactory, inasmuch as no one has ever seen a VFW representative at the hospital.

19. See 14 above.

20. There is insufficient floor space per patient, and crowding results. Reconversion of buildings has resulted in more bed space, but we believe that additional buildings for World War II patients are urgently needed.

21. The discipline and morale of the hospital personnel is of very high standard. No complaints.

22. We believe that the hospital could use to good advantage at least 250 additional beds for the new load of World War II patients.

23. As might be expected, there have been some few patients who disregarded medical advice and left the hospital, for reasons not directly connected with the facility. Records were unavailable for any percentage report.

24. We believe that better personal care could be furnished with the staff aide program of WAC's, trained in hospital routine. Younger women would improve conditions and raise morale, inasmuch as they would more readily understand the problems of the younger men.

25. No information.

26. No specific complaints, excepting those few malcontents always present in any like situation.

27. We would recommend in regard to the veterans' hospital, Livermore, Calif., that facilities be enlarged to reduce crowding, that additions to the staff be made in order that more personal care might be received—especially the addition of WAC's under the staff aide program, and approximately 30 or 40 corpsmen, more imaginative diets and menus, and more efficient and tasty preparation of meals. We believe that such changes would do considerable toward raising the patients' morale, and quieting dissatisfaction.

It is difficult to recommend any feasible program of entertainment, and we are inclined to believe that satisfactory arrangements can be made eventually.

Respectfully submitted.

N. DENNIS PERKINS,

*Adjutant, Chapter No. 7, Disabled American Veterans.*

HOMER SWIFT,

*Adjutant, Bronson M. Cutting Chapter No. 34, Disabled American Veterans.*

DANIEL A. MILLER,

*Commander-Elect, Chapter No. 7, Disabled American Veterans.*



# INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY OF THE ADMINISTRATION AND OPERA- TION OF VETERANS' ADMINISTRATION FACILITIES

THURSDAY, JUNE 28, 1945

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WORLD WAR VETERANS' LEGISLATION,  
*Washington, D. C.*

The Committee met at 10:20 a. m., Hon. John E. Rankin (chairman) presiding.

The CHAIRMAN. Dr. Griffith, will you come forward, please?

## STATEMENT OF CHARLES M. GRIFFITH, MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

Mr. McQUEEN. State your full name, Doctor.

Dr. GRIFFITH. Charles M. Griffith.

Mr. McQUEEN. Your position?

Dr. GRIFFITH. Medical Director, Veterans' Administration.

Mr. McQUEEN. How long have you been such?

Dr. GRIFFITH. Medical Director?

Mr. McQUEEN. Yes.

Dr. GRIFFITH. Since September 1930, sir.

Mr. McQUEEN. Now, as Medical Director of the Veterans' Administration, you have direct supervision of the hospitals and the medical personnel of those hospitals?

Dr. GRIFFITH. Under the rules and regulations; yes, sir.

Mr. McQUEEN. Now, Doctor, you have a statement there in regard to this investigation which has been going on. Would you care to put that statement before the committee at this time?

Dr. GRIFFITH. Mr. Chairman, would it be permissible for me to give you an over-all statement, verbal, of my difficulties, and my problems and then I will support it by memoranda, and by concrete details to the investigator or to whomever you want it to go to?

The CHAIRMAN. Submit them for the record?

Dr. GRIFFITH. Yes.

The CHAIRMAN. That would be all right, Doctor. I believe we would rather have it that way. It would be shorter and more to the point, and we would be in a position to understand it better.

Dr. GRIFFITH. Very well. Mind you, for everything I say, I have supporting evidence or can get it.

You may ask me questions that I have not thought of, but—



The CHAIRMAN. Well, all right, go ahead.

Dr. GRIFFITH. Up until the summer of 1940 or early fall of 1940, we had a hospital service that was second to none; not second to any in the country; but when they started to mobilizing the National Guard and calling in the Reserve, a large part of our personnel were either in the Reserve or in the National Guard; it was mandatory that the National Guard officers and enlisted men go into the service. When they called the officers in—I am speaking of medical officers now—at that time also there was called into service many of our best cooks, technical employees, such as plumbers and technicians of all kinds. All of that group of personnel was in the classified civil service. They were able to make replacements the first time, but, mind you, gentlemen, those employees that I speak of, who were called into service, were trained and had 15, 20, and 25 years' experience and they were thoroughly trained on their respective jobs.

The CHAIRMAN. You say "they," were able to make replacements.

Dr. GRIFFITH. I mean the hospitals in the decentralized group and for the centralized group, the Civil Service was able to make replacements; but they did not in either instance give us the trained personnel that we let go.

Then conferences were held with the Commission about the problem. Frankly, I was worried about it, because I did not think that the Commission would be able to give us the proper people we needed. They assured the Administrator on numerous occasions, the Civil Service did, that they could meet the situation. It was some of the higher officials of the Civil Service Commission that assured the Administrator that they would meet the issue. They will tell you now that they can. And then, as the war progressed, we had large numbers of personnel that were of military age; they were not in uniform. Hundreds of our younger and best doctors and nurses were told thousands of times by their friends, by their patients, and by others, "You are a slacker and you ought to get into the service." Now, you can imagine how that individual would feel about it.

Consequently, many of them resigned, when we were trying to hold them. They were assured that they would be protected if there was any way to protect them, but that did not meet the issue.

Later, others went, and each time the Commission in the case of centralized employees would replace, or the manager in the field would replace in those decentralized positions the previous incumbent with an individual whose quality was poorer than his predecessor.

Now, that did not apply to the Veterans' Administration's Medical Service, it applied to all branches, I presume.

The CHAIRMAN. To the Public Health?

Dr. GRIFFITH. The Public Health held most of their people, Mr. Chairman, because they have a commissioned service and they are exempt from the draft.

The CHAIRMAN. You are speaking now of both the medical and non-medical personnel of the Veterans' Administration?

Dr. GRIFFITH. Of the Medical Department of the Veterans' Administration. I am not talking about anything but medical.

The CHAIRMAN. I see.

Dr. GRIFFITH. Now, we appealed to the War Manpower Commission, and to various other agencies. We got to no help from them.

The Administrator went, on numerous occasions, to the War Manpower Commission, to the Selective Service, and to others, trying to retain some of the personnel, but with public sentiment demanding that every able-bodied man and woman go into the military service, they left, and if I was their age, and in their position, I would have done likewise. In fact, I did in '17.

Now, again, a factor that enters into the question of getting personnel. Since war was declared, all appointments are for the duration, i. e., temporary appointment, and any good, available, and competent employee, is not inclined to take a temporary position when he feels that as soon as this war is over, all of these jobs are going to ex-service men and women. Now, almost everybody has that feeling.

There has been considerable criticism about the selection of personnel.

Frankly, I think the operating agencies, meaning the directors of service, should have some say in the selection of their personnel, all types of them.

It is true that technically you can take your choice of one out of three. Say I need a doctor at station A. I want a general medical and surgical man. The Civil Service will give me three names. Personally, I do not know them. You have to decide on the history given. If you do not take the top man, then you have got to write a thesis explaining why you did not, and I mean "thesis."

The CHAIRMAN. You must take one of the three?

Dr. GRIFFITH. Yes, sir. And even after you have rejected them, and if you ask for one next week, they will send you that same man back, and then you have got to do it all over again.

In reading various reports, there is a lot said about "too much central office control." If you did not have central office control over these field stations, you would be running 96 different ways.

It has been said they do not have selection of doctors. Since the war has progressed, we have permitted the field to pick up all types of medical personnel. Eight doctors were certified to me for placement to go on. They all had a penitentiary record, and they were either about vice or trading or dealing in narcotics, or things of that character.

Mr. ALLEN. You mean the Civil Service Commission certified them?

Dr. GRIFFITH. No, wait, I said we gave the field authority, the local managers authority to employ men temporarily.

Now, the field managers had no way on earth of knowing these men's past records. We and Washington do. We can check through the FBI and through various services and get the record. That is how we picked their records up.

Now, if he is an undesirable doctor, and he has been in trouble in California, he is applying in Chicago or New York to the local manager, and he will give you a beautiful story. The manager is short of doctors and nurses—

The CHAIRMAN. Doctor, let me get that statement you made clear. These were not civil-service doctors?

Dr. GRIFFITH. No, sir.

The CHAIRMAN. But when you went out into the field—

Dr. GRIFFITH. The manager picked them up and they were to be put on duty, and then the Civil Service Commission would classify them.

The CHAIRMAN. Yes; but even after you selected them, you had to submit them to the Civil Service?

Dr. GRIFFITH. Yes, sir; because they had to be classified.

Mrs. ROGERS. It would seem to me, Doctor, that you have not much faith in your district managers.

Dr. GRIFFITH. I would not put it that way, Mrs. Rogers, because the local manager does not know the entire background and training of the individual.

Mrs. ROGERS. Well, he ought to be able to find it out.

Dr. GRIFFITH. If the doctor is sworn in and takes office, the manager writes to us to get it.

The CHAIRMAN. The only agency that I know which can dig up the background of an individual thoroughly is the FBI.

Dr. GRIFFITH. That is what we have used, Mr. Chairman.

The CHAIRMAN. I have tried them all. I will tell you now I have had some people investigated with reference to positions lately and I have been thoroughly shocked when the FBI did investigate them and found out their real record.

Mr. GRIFFITH. That is right.

We picked up these narcotic cases through the Narcotic Bureau. That is where we got those.

The CHAIRMAN. You mean you had the FBI check upon them?

Dr. GRIFFITH. Well, we had that service do it. In the narcotic cases, we picked them up through the Internal Revenue Department. We had applicants that were trading and trafficking in narcotics.

The CHAIRMAN. Let me pause just a minute. I want to remind the lady from Massachusetts that it has been less than 10 years and probably less than 5 years since one of the greatest thieves of this country jockeyed himself into the presidency of McKesson & Robbins, one of the greatest drug firms in America and they did not know it because they did not have access to the very facilities he is talking about, the FBI.

Mrs. ROGERS. It seems the Medical Association ought to have some way of checking up on those doctors. Have they no procedure of that kind?

Dr. GRIFFITH. Sure, we check with the medical associations, national associations, Mrs. Rogers, we check with every avenue we have on that man. We go to his locality.

Mrs. ROGERS. Your district managers do?

Dr. GRIFFITH. We do.

Mrs. ROGERS. Well, they ought to be instructed to.

Dr. GRIFFITH. I know they ought to and they have been instructed to. I am going to get back to that situation three or four times, Mrs. Rogers.

The CHAIRMAN. Another thing, Doctor. Let us get this straight as we go along.

In order to get the assistance of the FBI, the request has to come from the head of some governmental agency?

Dr. GRIFFITH. Yes, sir.



The CHAIRMAN. So therefore the men out in the field would have to come to the central office to get a request for the FBI to check up on a man?

Dr. GRIFFITH. Or the Bureau of Investigation, Internal Revenue, or whatever agency is involved.

Mrs. ROGERS. A Medical Corps bill would take care of that; would it not?

Dr. GRIFFITH. Well, could I reserve that for a few minutes later?

Mrs. ROGERS. Yes, indeed.

Dr. GRIFFITH. Now, regarding nurses, we have permitted the field, and do still permit them, to recruit nurses. They send their record in, the school of graduation, and so forth, and it has to be a grade A school, recognized by the State. But after all nurses resign to go to service and into other jobs, just as the doctors. We have several hundred nurses in military service today. We have over 450 doctors in the armed forces.

The CHAIRMAN. There is a roll call on the floor and if there is no objection the committee will adjourn at this time to reconvene tomorrow morning at 10, as I wish all the members of the committee to be present when Dr. Griffith resumes his testimony.

Mr. SCRIVNER. Mr. Chairman, before we suspend, I asked the Administration to prepare a statement for the committee showing the turn-over in personnel prior to selective service on down to the present date.

It shows the number of physicians and number of nurses and the attendants, beginning with June 30, 1940, and it is interesting to note, for instance, from June 1944 on up to April 30, 1945, that there was a 43 percent turn-over in nurses alone, and possibly an 80 percent turn-over in attendants.

The same thing was true for June 30 of 1943 to June 30, 1944, when, in order to keep 15,000 attendants on the job, they had to hire 11,047; in other words, 80 percent turn-over, and I think these figures, which have been tabulated, would really disclose some of the conditions that the Administration is facing.

That does not remedy the conditions in the past, but it might be a guide for the future.

The CHAIRMAN. It may be inserted.

(The tabulation is as follows:)

Veterans' Administration statement showing the status of full-time physicians, nurses, and attendants for selected dates

Dates	Physicians (full time)				Nurses			Attendants (excl. memb. pas) <sup>1</sup>			
	Author- ized	Filled by civilians	Filled by commis- sioned officers	Actual vacan- cies	Author- ized	Filled	Vacancies	Author- ized	Filled by civilians	Filled by enlisted men	Actual vacan- cies
June 30, 1940.....	1,711	1,657			4,257	4,116	141	16,556	15,895		661
Total hired or assigned during year.....		305				782			7,863		
Total separated from service during year.....		297				513			7,076		
June 30, 1941.....	1,790	1,755	35	35	4,536	4,385	151	17,328	16,682		646
Total hired or assigned during year.....		357				875			10,667		
Total separated from service during year.....		396				1,037			10,969		
June 30, 1942.....	1,815	1,716	99	99	4,670	4,223	447	17,883	16,380		1,503
Total hired or assigned during year.....		130				1,228			12,189		
Total separated from service during year.....		197				1,595			13,545		
June 30, 1943.....	1,747	1,649	98	98	4,455	3,856	599	17,050	15,024		2,026
Total hired or assigned during year.....		216				1,349			11,047		
Total separated from service during year.....		1,046				1,284			11,224		
June 30, 1944.....	2,294	1,819	1,098	317	4,857	3,911	946	18,350	14,817	2,025	1,478
Total hired or assigned during year.....		102				1,701			( <sup>2</sup> )		
Total separated from service during year.....		302				1,159			( <sup>2</sup> )		
April 30, 1945.....	2,528	619	1,690	219	5,450	4,453	997	20,606	14,828	4,416	1,362

<sup>1</sup> Attendants include hospital attendants, barber, mess attendants, waiters, cooks, bakers, maids, housekeepers, matrons, seamstresses, and laundry helper.<sup>2</sup> Not available.

NOTE.—(a) Figures indicated for additions and separations to the rolls are approximate. (b) The filled positions of physicians include the following assigned to rating boards June 30, 1940, 145 civilians; June 30, 1941, 137 civilians; June 30, 1942, 139 civilians; June 30, 1943, 131 civilians; June 30, 1944, 236 civilians; June 30, 1945, 126 commissioned officers; June 30, 1943, 136 civilians, 171 commissioned officers.

Mr. DOMENGEAUX. Mr. Chairman, are these hearings being printed?

The CHAIRMAN. They are going to be just as soon as we have finished with these Veterans' Administration employees.

Mrs. ROGERS. Mr. Chairman, I understood the committee was going to call the man who made the investigation of the situation at the Lyons Hospital in New Jersey.

The CHAIRMAN. I do not know. We are going to hear these Veterans' Administration people first.

We will meet tomorrow morning at 10 o'clock, Doctor, and we will hear your testimony at that time.

(Whereupon, at 12 noon, the committee adjourned, to reconvene Friday, June 29, 1945, at 10 a. m.)





# INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY OF THE ADMINISTRATION AND OPERA- TION OF VETERANS' ADMINISTRATION FACILITIES

FRIDAY, JUNE 29, 1945

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WORLD WAR VETERANS' LEGISLATION,  
*Washington, D. C.*

The Committee on World War Veterans' Legislation met in the committee room, Old House Office Building, at 10 a. m., Hon. John E. Rankin (chairman) presiding.

Chairman RANKIN. The committee will come to order.

Dr. Griffith, yesterday when you were testifying you said something about the undesirables and undesirable people being offered to the Veterans' Administration. In order that the members present may have that picture, I wish you would repeat that statement.

Dr. GRIFFITH. I will sir.

Chairman RANKIN. Just give us that part of your testimony.

Dr. GRIFFITH. Yes, sir.

Chairman RANKIN. You may proceed.

Dr. GRIFFITH. I was talking, Mr. Chairman, about the difficulties in decentralizing recruitment of personnel. Each manager was given authority to recruit, but the local manager does not have all the picture of an individual.

Chairman RANKIN. What is it he does not have?

Dr. GRIFFITH. All of a man's background, training, experience.

Chairman RANKIN. I see.

Dr. GRIFFITH. Now, a man may be in trouble or he may have had a penitentiary record in California. Now, he would not apply locally there but he would come, say, to Chicago or New York or Atlanta, and he would present himself to the manager and outline his own qualifications and specifications. They would look good, of course, and he would picture them that way, but the papers have got to come in to the Washington office. Then we have more access and ways of finding out about that man's past record, his efficiency, and we are able to find out more about the man than the local manager can. Do I make myself clear there?

Chairman RANKIN. Yes, sir.

Mr. BENNETT. May I ask a question?

Chairman RANKIN. Mr. Bennett.

Mr. BENNETT. There is great need of this personnel and in the meantime would you permit the local manager to make recommenda-

tions in regard to these men? In other words, are these people put on temporarily and then investigated?

Dr. GRIFFITH. They are picked up and started. They do the work of the office but they are on a temporary basis and then we have got to get rid of them if they are undesirable.

Mr. BENNETT. In other words, the local managers were in an embarrassing position through no fault of their own. It also reflected on you that these fellows who had bad records that you referred to yesterday, that they were put to work temporarily and you could not get rid of them until you had a complete investigation.

Dr. GRIFFITH. We wanted a complete record of them.

Mr. MATHES. How long were these people in the service before you got rid of them?

Dr. GRIFFITH. We got rid of them immediately.

Mr. MATHES. I mean over what period of time?

Dr. GRIFFITH. I would say within 30 days.

Mr. MATHES. Within 30 days you would have had the check completed?

Dr. GRIFFITH. And disposed of.

Mr. MATHES. Even though they were sworn in and had a temporary status, they were immediately removed?

Dr. GRIFFITH. The personnel director got rid of them. I do not know all of that technique.

Mr. MATHES. How many of them were there?

Dr. GRIFFITH. Not so many; six, seven, or perhaps a dozen.

Mr. MATHES. What part of the country were they from?

Dr. GRIFFITH. Various parts.

Mr. BENNETT. You say that they had records?

Dr. GRIFFITH. Yes, sir.

Now, Mr. Chairman, quite a lot was said about nurses and the recruitment of nurses. Under civil-service a nurse was considered subprofessional and did not have a professional status with the Civil Service Commission. However, all other agencies, military and civilian institutions, gave a nurse a professional status. That stopped hundreds upon hundreds of nurses from coming with us. The Administrator worked on numerous occasions and tried to accomplish something with the classification people and the Civil Service people.

Chairman RANKIN. Who did you say would not give the nurses a professional status?

Dr. GRIFFITH. I said the Civil Service would not give them a professional status but classified them as subprofessional.

Mr. ALLEN. Could they have given them a professional status?

Dr. GRIFFITH. Congressman, you have got me there. The Civil Service Commission said that there were certain acts of Congress, and I do not know them, which prevented them from doing it. Now the Administrator argued the thing for a year and then said he would give them a professional status and did as of July 1 of this year.

Chairman RANKIN. Who was that?

Dr. GRIFFITH. General Hines. Now the Commission argued the thing for the last 3 years and I do not know why they did not give it to them.



Now during the year 1942 we recruited 1,419 nurses. Those nurses would come on duty. They were promptly told by the personnel on duty and by the patients that they were only appointed for the duration. They would be told: "You are an able-bodied young woman and you should go into the military service." Most of them promptly did.

In 1943 we recruited 1,087 nurses and assigned them to duty. Now each month, say, we recruited 500 nurses; the resignations would just exceed the appointments from 5 to 10 percent at least, letting the load go on down each month.

Mr. SCRIVNER. Does that schedule that we received yesterday show that?

Mr. McQUEEN. Another reporter has that and it has not been returned. Do you want me to order it over?

Mr. SCRIVNER. Yes.

Dr. GRIFFITH. Now I am not going into all the details verbally, but here are several pages of what we accomplished and what we did, and I am going to turn them over for the committee.

Chairman RANKIN. You may submit it for the record.

(The data referred to are as follows:)

Office Memorandum, United States Government.

JUNE 14, 1945.

To: Dr. Griffith, medical director.

From: Superintendent of nurses.

Subject: Recruitment of nurses.

The following steps have been taken to encourage nurses to remain with the Veterans' Administration and to assist in recruiting nurses:

1942: During this year 1,419 nurses were assigned.

1. Managers were given authority to recruit locally on full-time or part-time basis.

2. Approval was granted to all employees who requested release from quarters and subsistence, and optional charge for quarters and subsistence for all new employees.

3. Position of nursing assistant was established.

4. Physical requirements were modified.

5. Age requirements were waived.

6. Five temporary positions were established at each facility for local appointees who were available for transfer in accordance with the needs of the service.

7. Professional status for nurses requested.

1943: During this year 1,087 nurses were assigned to duty.

1. In an effort to attract nurses all junior graduate nurse positions, \$1,620 per annum, were changed to graduate nurse positions, SP-5, \$1,800 per annum.

2. Authority was given to assign Red Cross volunteer nurse's aides to general medical and surgical hospitals.

3. Affiliate courses in eye, ear, nose, and throat, and surgery, and psychiatric nursing were commenced in two facilities.

4. Contacts were made with the various State boards of nurse examiners to obtain approval of Veterans' Administration facilities for senior cadet nurses.

5. Nurse-teaching positions were established at two facilities.

6. Assistant to superintendent of nurses appointed.

7. The reclassification of nurses, dietitians, and physical therapy aides was again requested.

8. Graduate nurse trainee position was established for nurses who did not meet the United States civil-service qualifications, but who were graduates of recognized schools of nursing and registered in a State or the District of Columbia.

1944: During this year 1,588 nurses were assigned to duty.

1. Four facilities were approved for affiliate student nurses.
2. Thirty-three facilities were approved for senior cadets.
3. Name and address of chairman of State committee for nurses, Procurement and Assignment Service, were sent to the manager of each facility.
4. Releases for publication were sent to the following:
  - (a) Disabled American Veterans and the Veterans of Foreign Wars, expressing our need for nurses.
  - (b) Mrs. Alice McLean, president, American Women's Volunteer Service, Inc.
  - (c) All State nursing journals, and the Hospital magazine.
5. In May, the senior cadet folder was submitted for publication.
6. Two memoranda were again submitted on the reclassification of nurses from subprofessional to professional status.
7. Recommendation for the commissioning of nurses did not meet with the approval of the War Department.
8. Authority was given to prepare a folder explaining the Nursing Service of the Veterans' Administration to be distributed to prospective applicants.
9. Release of radio fact sheet for Horace Heidt (Urgent Need for Nurses to Care for the Nation's Veterans).
10. Authority granted for five field representatives to visit schools of nursing and procurement and assignment district offices in five sections of the country to interest students and graduate nurses in the Nursing Service of the Veterans' Administration.
11. "Open House" in Veterans' Administration facilities for student nurses, from 1:30 to 4:30 p. m., November 1, 8, 15, and 29.
12. The appointment of a committee of five leaders in the field of nursing as an advisory council for the service.
13. Postgraduate study for nurses approved October 7, 1944.
14. November 24, 11 nurses assigned to take an active part in special programs for senior cadets. These 11 nurses were detailed to report on nursing activities in the Veterans' Administration. Meetings were held in all of the larger cities of the United States.
15. Request for detail of public relations consultant to have charge of the nurse recruitment program was made October 11 and November 3. Assignment of this consultant effected December 19.
16. Appointment of second assistant to superintendent of nurses, September 1.

1945:

1. Approval of reallocation of 804 staff nurse positions to head nurse positions, February 2.
2. Master Bibliography of Nursing Textbooks letter sent to each facility.
3. May 1, approval was granted for the establishment of a policy of rotation of nurses assigned to isolated stations.
4. Four nurses detailed to Wayne University, Detroit, Mich., for special course in tuberculosis nursing.
5. Two nurses detailed to Western Reserve University for special course in orthopedic nursing.
6. Two nurses detailed to take course in ward management and administration at University of North Carolina.
7. Miss Marie H. Hamel, of Oteen, N. C., detailed to Durham and Winston-Salem, N. C., to contact student nurses. This detail also included authority to contact nursing organizations and other training schools in North Carolina and adjoining States.
8. Nurse representative from central office detailed to visit:
  - (b) Yale University School of Nursing.
  - (a) Vanderbilt University School of Nursing.
  - (c) To attend State procurement and assignment meeting, Harrisburg, Pa.
  - (d) To attend National Nursing Council for War Service meeting. Special meeting of all senior cadets from schools of nursing in Philadelphia, Pa.
9. As of June 1, 321 senior cadets have completed their senior cadet period in Veterans' Administration facilities. There are presently on duty 679 senior cadets in 33 facilities.

The difficulties encountered since the war have been the facts that Veterans' Administration nurses were not in a professional status and were not given the

benefits of hospitalization nor a clothing allowance, etc., as was done by both the Army and the Navy. It was therefore necessary for the Veterans' Administration to employ those nurses who were not eligible for service with the armed forces.

The Veterans' Administration does have an 8-hour workday. Transportation and housing have played a major part in our efforts to obtain nurses. The Administrator has ordered that nurses be placed in a professional status as of July 1, 1945. It is believed that this will materially aid our recruitment program. The discontinuance of recruitment programs by the Army and the Navy will result in more well qualified young nurses being available for assignment to the Veterans' Administration.

The following table shows the number of nurses and attendants authorized and the number on duty:

Date	Nurses		Attendants	
	Authorized	On duty	Authorized	On duty
Dec. 1, 1941.....	4,617	4,390	10,825	10,302
Dec. 1, 1942.....	4,678	4,044	10,850	9,602
Dec. 1, 1943.....	4,508	3,788	10,395	8,758
Dec. 1, 1944.....	4,983	4,150	11,389	8,524
May 1, 1945.....	5,450	4,533		
Dec. 1, 1944 (servicemen).....				931

The following is an outline of the program and activities of the nurses recruitment specialist for the recruitment of nurses, from December 15, 1944, to June 1, 1945:

**Direct mail:**

Letters to graduating student nurses.....	23,000
Letters to directors of schools of nursing.....	1,100
Letters to graduate registered nurses (names furnished by Procurement and Assignment Service, War Manpower Commission).....	31,000
Follow-up letters with application forms to graduate registered nurses...	2,400
Letters sent out by American Red Cross to nurses rejected for Army Nurse Corps, containing material furnished by Veterans' Administration...	3,000
Letters to nurses rejected for Army Nurse Corps.....	5,000
Letters to individual nurses, with application forms, in reply to requests for information.....	3,000

**Materials prepared:**

Leaflets, Opportunities for Nurses.....	250,000
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**Distribution as follows:**

By National Council for War Service through 200 local chapters; American Red Cross through 3,700 local chapters; Elks through 1,000 local lodges; 1,100 through schools of nursing; 48 State procurement and assignment services.....	200,000
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As enclosures in direct mail and miscellaneous channels....	50,000
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Return cards for use in direct mail.....	35,000
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Fact sheets for media (newspapers, magazines, organizational publications, etc.).....	3,000
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Fact sheets on joint Recruitment for Women campaign sponsored by Office of War Information, American Red Cross, and National Retail Dry Goods Association.....	1,000
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Advertisements for newspaper releases by Elks throughout the Nation...	3,000
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Copies monthly beginning May 1 of a Nurse Bulletin—a house organ instigated and designed for the purpose of building morale among the nurses in the employ of the Veterans' Administration and decreasing the attrition rate.....	5,000
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Supplement No. 1 to fact sheet for media.....	3,000
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**Miscellaneous materials:**

1. Form letters for direct mail.
2. Radio scripts for spot announcements and interviews (used handled through OWI).
3. Articles for professional magazines, organizational publications.
4. Special material for use by OWI and individual publications as requested.

**Materials in preparation:**



Folders for distribution to graduate registered nurses----- 200, 000  
 Posters for display in strategic places, professional association offices,  
 schools of nursing, medical buildings, etc----- 100, 000  
**Publicity:**

Nation-wide through daily press, national magazines, trade, professional, and organizational publications. Material is prepared by Nursing Section of the Medical and Hospital Service, cleared through OWI, and released by Veterans' Administration or OWI, depending upon type of release.

Radio is being used on a regional basis in areas of greatest need for nurses. Material is prepared by Veterans' Administration, distributed by OWI. Broadcasts are arranged through OWI.

Spot radio announcements have been broadcast on local stations by the Elks, using announcements specially prepared for them by OWI from material furnished by the Medical and Hospital Service.

**Personal solicitation:**

Carried on by members of the Elks War Commission in approximately 1,000 communities under the supervision of the Medical and Hospital Service.

**Summary:**

Despite the fact that subprofessional status of nurses in the Veterans' Administration has prevented the Medical and Hospital Service from demonstrating its ability to recruit the desired number of nurses, reports from managers show 1,433 nurse appointments and 678 separations with a net gain of 907 nurses from the inception of our nurse recruitment activities by the Elks War Commission, September 1944 to June 1945.

A new recruitment program is now being developed as a result of reclassification of nurses in the Veterans' Administration from a subprofessional (SP) to a professional (P) grade. Instigation of new educational programs, adoption of policy of automatic rotation of nurses from isolated stations after 2 years of service and cessation of competitive recruitment.

**Summary of proposed program to appeal to graduate registered nurses:**

1. Direct mail to—

- (a) Army surplus.
- (b) Army civilian releases.
- (c) War Manpower lists.

2. Personal contact with individual nurses and nursing associations and groups by Veterans' Administration nurses and Veterans' Administration liaison field personnel.

3. Indirect contact through:

- (a) Civil service.
- (b) Publicity.
- (c) Distribution of posters.
- (d) Distribution of folders.
- (e) Incorporation in National Nursing Planning Committee postwar plans.
- (f) Professional publications.
- (g) Others.

**Summary of proposed program to appeal to cadet nurses, graduating student nurses through:**

- 1. Schools of nursing.
- 2. Division of nurse education field staff (if approved by Miss Petry).
- 3. Publicity.
- 4. School and cadet publications.

**Program of public information to emphasize:**

- 1. Need for nurses in Veterans' Administration hospitals.
- 2. Develop an understanding of good nursing practices.
- 3. Create public demand for good nursing practices.
- 4. Acquaint public with the Veterans' Administration Nursing Service.
- 5. Opportunity for career with the Veterans' Administration.

It is believed that recent benefits granted nurses in the Veterans' Administration and the cessation of competitive recruitment will enable the Medical and Hospital Service to secure nurses to meet the present critical need, and, by careful planning, selection, and placement, establish a nucleus of highly qualified nursing personnel for the postwar nursing service.

GWEN H. ANDREW.

Mr. SCRIVNER. May I ask this question? There is one thing which rather disturbed me in all this, that we get these complaints of the difficulties of the veterans. I myself have received many complaints about attendants, doctors, and nurses, but during all this period of time, beginning as far back as 1940, as far as I have been able to find out, there has never been any efforts made to straighten that out.

Dr. GRIFFITH. Congressman, it wasn't solely a controversy between the Civil Service and the Administrator.

Mr. SCRIVNER. But in all that time I have no knowledge that the Administrator came to this committee with his problems. If there was any efficiency, why we were willing to cooperate with the Administrator and give him whatever remedial legislation he asked. I do not think the committee ever turned him down.

Dr. GRIFFITH. Possibly the Administrator did not think in 1940, 1941, and 1942 that it was as serious as it was.

Mr. SCRIVNER. Well, he certainly should after Pearl Harbor. He certainly should have realized it was serious.

Dr. GRIFFITH. Congressman, I would much rather you asked the Administrator that.

Mr. SCRIVNER. I will.

Dr. GRIFFITH. Now, I would like to emphasize this point: Previous to 1940 we had trained team units of nurses, technicians, medical, and various staff personnel. I will try to illustrate this way. Take 20 trained doctors who work on a team. They all had different personalities but they have learned to adjust and to give and take, and a trained team of 20 can do twice as much as an untrained team of 50.

Now at present we have about 2,235 doctors on duty, representing all classifications, and about 75 percent, or 74 percent and a fraction, are in uniform. The others are civilians who are strictly under civil service. Now there has been a whole lot of talk about this compensatory time off. The Army has a regulation that you have got to do certain things and this has got to be verified—under a Ramspeck bill a doctor either had to have overtime if he worked over 8 hours or compensatory time. Now when you take in the holidays and take in all this compensatory time stuff that he has to have off duty, I am not in sympathy with any of that. Now there is a law that you have got to live up to, I know that. I was told, and maybe I am of the old school and out-of-date, but I was taught a doctor had a job to do and if it took 8 hours, 10 hours, or 12 hours to do, to go ahead and do it.

Mr. ALLEN. I was just going to ask you that, Doctor—if it is possible for a man treating sick people to work by the watch.

Dr. GRIFFITH. Congressman, I was going to make you a speech on that. I do not know why, but for the last 1,000 years people flatly refuse to have a pain by the clock or die by it, and you cannot legislate laws for a doctor that will apply to a plumber, a technician, a carpenter, or an engineer. Gentlemen, people just do not die by the clock and they do not die by civil-service regulation.

Mr. ALLEN. He is right.

Mr. SCRIVNER. Mr. Chairman, let me interpose and state frankly that I know there are doctors in the veterans' hospitals who do not work by the clock and do not ask for compensatory time, and they are there day in and day out and do not ask for time off.

Dr. GRIFFITH. You did not let me finish. I was going to state that. I am going to make a statement that 75 percent of our doctors of the whole regular group I will put against any group of doctors in the United States. Seventy-five percent of those doctors will work after dinner, work in the evenings. If they have a sick man on their ward, they will make tours of duty and check on him all through the night. I have operated for 10 years in hospitals, either operating or running one. I have operated all day long and then I would have two or three emergencies at night and I would go back at night and I would go to see my acutely sick and ill patients.

Now there has been a lot said about a doctor not spending over 4 or 5 minutes a day with a patient. Seventy-five percent of our doctors are spending a lot more and they are giving all the time necessary to their patients.

Now I am going to take up another point. It has been stated that we have become specialist crazy. What I mean by that is this: That you have got to have a special NP examination on everybody; you have to have a special heart examination; you have to have a special lung examination; and so on and so forth. Now that all takes time. We have been criticized about holding a man in the hospital too long or over the prescribed time if he were in a civilian hospital. Now we have found that it is much more economical and much more satisfactory to make a complete examination of the individual, even if we were only going to do a compilation. Now all that is necessary for recruitment purposes, claims, insurance, and all the rest of them. The veteran may not have all the compensation he is entitled to. It is all based on the rating of the veteran from a physical and mental standpoint. The various boards use that information as a yardstick. The final decision must be made on the physical and mental finding of that individual. Now if you do not make a complete examination of the veteran is going to say later on that he did not get an NP examination or that he did not get a heart examination, and so on and so forth, and that is why we do it and it pays dividends.

Now, out of the two thousand three hundred and seventy-odd doctors, I will state that 75 percent of them are good, and I have also stated I will put them against anybody. I do not say they have not made mistakes; any doctor that handles a lot of patients is going to make errors. You had some international consultants of ours the day before yesterday. They make mistakes. You gentlemen make mistakes, and any man that does anything and makes decisions is going to make errors. However, we do not want to make the same error twice. Our nurses and doctors are working there, and they are giving good service. It would take a truck to haul over here the letters that came in to the Administrator and my service, commendatory and appreciative of the service rendered. However, those are not mentioned in all of these investigations.

Now, going back to the military, we know 450 of our best doctors went into the military service. About 250 of them are still in the service. We had 988 nurses go out at one time to go into the military service. We had 106 of our best-trained technicians to go into the military service.

Now, to get replacements: Now, mind you, gentlemen, at the same time those people left us, the armed forces were combing the country for every type of technical personnel, medical personnel, and nurse



personnel. Now the situation is bettering. Now, I am going to tell you, gentlemen, that it is going to be worse than this 5 years from now, and I am going to tell you why.

There are approximately 500,000 who went into the WAVES, WAC's SPARS, and lady marines.

Mrs. ROGERS. Are you sure of your figures on that?

Dr. GRIFFITH. Yes.

Mrs. ROGERS. I think you will find it is higher than that.

Dr. GRIFFITH. I was told by the military forces that group of young women, able-bodied and young, and the student and college group, is where you would get your technicians, your nurses, and your various individuals. Now, the Army is training a lot of those girls in technical work. They had to do it because there was nobody left at home to do it and nobody else to get.

Mrs. ROGERS. You had no inducement for them to go into your service.

Chairman RANKIN. Let him finish his statement.

Mrs. ROGERS. I just wanted to get that in.

Chairman RANKIN. Let him finish. He wants to tell us why there will be a scarcity in 5 years.

Dr. GRIFFITH. That does not apply only to nurses and technicians, gentlemen, but rather as well to the young medical students, because they are the people that would be entering the freshman class in college this session. I am told by eight deans of national schools that they are only getting about 35 percent of their classes, and that happened last year, and it will happen next year.

Mr. ALLEN. Thirty-five percent of the graduates?

Dr. GRIFFITH. Of the original classes, say, as of Pearl Harbor, we got 200; now, it is hard to have a freshman class that will have more than 35 percent of that.

Mr. DOMENGEAUX. Pardon me, Doctor, but what is going to happen to all of this personnel that is in the Army now?

Dr. GRIFFITH. The Army is not training them.

Mr. AUCHINCLOSS. Suppose we let the witness go on and finish his statement.

Chairman RANKIN. He is starting to tell why we will have a shortage 5 years from now.

Dr. GRIFFITH. They are not graduating doctors and nurses because they did not get the applicants. The applicants are in the Army, both male and female. Now, there is going to be an interval of 4 years, and I think it started about 2 years ago, when they had a drop off of admissions to the medical colleges. It was terrific. It will be worse this year. That is why all these consultants are talking about this post-graduate training and education. Now, there are hundreds of medical students who went out. They had just finished their internship. They wanted additional training, and that is what this is all about. Take the man who talked to you the other day.

Now there are just so many doctors in the United States. I want you to stop and think about the shortage of doctors in the armed forces and in the Veterans' Administration. Take 95 percent of the soldiers and the nurses and the people in the Army of today. They did not call a doctor three times a year in most cases when they were in civilian life. If they did have a doctor, it was possibly because of some accident. Now you have a certain percentage of doctors and

nurses of so many per thousand soldiers. Maybe they are busy and maybe they are not, but they are all in the service. Now we have a ratio.

Now there has been a lot said about—that we were only handling custodial cases before the war. We were handling some custodial cases. We were handling World War I men of all kinds, accidents, injuries of any ex-serviceman, injuries that would happen to anybody. We had acute surgery of all types, brain surgery and all types of acute conditions. Maybe you said we were not running an acute hospital, but whoever said that just does not know what he is talking about. We did. Why any ex-serviceman would come there for an appendectomy or any trouble of any kind or ordinary accident; he would come in and get the service.

Now we are taking on a new crew. We have made arrangements to take care of tropical diseases, including all of the fungous diseases that are not customary in the United States. All those have been taken care of.

Now there has been a lot said about research.

Chairman RANKIN. How about the shortage 5 years from now. These doctors are coming back from the Army, and the Wacs and Waves are coming back, and won't they be available?

Dr. GRIFFITH. A lot of them coming. Mr. Chairman, will be available, but I am talking about the over-all picture. We are not graduating young doctors today as compared to what we were prior to Pearl Harbor. They are not available. They are in the service acting as soldiers.

Chairman RANKIN. Well, it was bad enough before Pearl Harbor, but it seems that there has been a certain dictatorship which has taken over the nursing and medical associations and put restrictions around them and driven the old-line nurses out of the profession.

Dr. GRIFFITH. That is true, and may I comment on that?

Chairman RANKIN. Yes, sir.

Dr. GRIFFITH. Up to now, after a student has finished the graduate course he has got to take practically 4 years in college and preparatory and premedical work before entering the 4 years in medicine, and then it takes him 1 year's internship, and there is 9 years and it is quite expensive.

Chairman RANKIN. Isn't it a fact that these requirements set up by the medical profession have prevented many fine young men who did not have considerable money from going to college to study sociology and all those subjects?

Dr. GRIFFITH. That is right.

Chairman RANKIN. But if many of these young men had been permitted to go to college, they might have made some of the best doctors in the country.

Dr. GRIFFITH. That is right, sir.

Chairman RANKIN. They are driven from the medical profession because they are not able to comply with the requirements fixed by the medical profession.

Dr. GRIFFITH. Yes. I think they require too much of the students. The average boy who has got to make his way cannot study medicine today.

Chairman RANKIN. In other words there are certain elements trying to make of the medical profession a closed shop.

Dr. GRIFFITH. Well it takes plenty of money to do it.

Chairman RANKIN. How much money, doctor, does it take to prepare a man to be a doctor now?

Dr. GRIFFITH. Thirty years ago it cost my father \$10,000 to graduate me.

Chairman RANKIN. What would it cost today?

Dr. GRIFFITH. It costs much more than that.

Mr. BENNETT. Twice as much?

Dr. GRIFFITH. Possibly.

Chairman RANKIN. I have been told, although I do not know whether or not it is true, but I have been told it costs around \$25,000 on an average, and if a young man had \$25,000, he would be more likely to use it to go into something else rather than utilize it for that purpose.

Dr. GRIFFITH. Yes, sir.

Chairman RANKIN. And as a result—now I am bringing it home to you, because this has been worrying me for a long time—I was born and largely reared in a county, a small inland county, of Anglo-Saxons. Ninety percent of the people were Scotch, English, Welsh, or Irish. Well, now, there were a large number of those young men went to medical college and it looked as if we had a local doctor at every crossroad.

Dr. GRIFFITH. Yes.

Chairman RANKIN. Today the young men are virtually driven out of the medical colleges.

Dr. GRIFFITH. That is right.

Chairman RANKIN. Young men do not go in for that any more.

Dr. GRIFFITH. That is right.

Chairman RANKIN. And while 30 years ago they were furnishing doctors for the surrounding areas and it includes some of the doctors you have in the Veterans' Administration who are from that county, today they are literally driven from the medical profession.

Dr. GRIFFITH. Yes, sir.

Chairman RANKIN. In that county we have only five doctors and every one of them is at least 60 years old. Now, if that condition prevails throughout the country, we will soon have a deficiency of doctors over the country.

Mr. SCRIVNER. Mr. Chairman, there is nothing this committee can do about it.

Chairman RANKIN. How is that?

Mr. SCRIVNER. There is nothing that this committee can do about it.

Chairman RANKIN. I am not so sure. This committee can recommend legislation to Congress.

Mr. SCRIVNER. I do not think Congress has anything to do with it.

Chairman RANKIN. All right; but the same thing will be reflected in the veterans' problem.

Dr. GRIFFITH. Yes, sir.

Chairman RANKIN. That is the point he is bringing out.

Dr. GRIFFITH. That is the point I want to make.

Mr. DOMENGEAUX. I would say that 60 percent of the doctors before the war were young men under 35 years of age, but I do not know of any ambitious boy in my county who wants to study medicine. It may be different in other places.



Mr. ALLEN. We have a medical college at Louisiana State University and they can go down there at nominal expense.

Mr. ERVIN. Your comment is that there are no freshmen there.

Dr. GRIFFITH. Can we proceed with the bill?

Chairman RANKIN. Go ahead.

Dr. GRIFFITH. Now, gentlemen, you people made visits to these hospitals and you were told you could not get the postgraduate work and that the medical director and the Veterans' Administrator would not give postgraduate work. Let me go back 10 years ago. The Administrator authorizes me to give postgraduate training. I had one requirement and that was to find out if the man intended to stay with the Veterans' Administration. We made them sign a statement that they would remain at least 3 years. We spent as much as \$2,000 to \$3,000 on postgraduate work on the individual. We made an all-out good doctor of him and what did he do? The majority of them resigned and went into jobs at \$3,000 to \$5,000 more a year in private practice than we could pay them, and the Administrator wanted to curtail it and I did not blame him.

Now, since 1943 we have issued and authorized 33 different courses in the various nationally known and outstanding State universities, and I will submit that for the record.

Mrs. ROGERS. How many are taking those courses, Doctor?

Dr. GRIFFITH. They figure on 25 in a course. We may want to give a certain individual some more training in eye, ear, nose, and throat, or in neurology or in any one of numerous specialties.

We have three schools—one at the Mayo Clinic, one in New York, and one in Chicago—where we have 17 to 18 men taking the courses, which vary from 2½ to 3 months.

Chairman RANKIN. Without objection, the statement of postgraduate instruction for medical officers may be inserted in the record at this point.

(The statement is as follows:)

#### POSTGRADUATE INSTRUCTION FOR MEDICAL OFFICERS SINCE JULY 1, 1943

1. Course in anesthesiology; Mayo Clinic; 3 months; five physicians.
2. Course in bronchoscopy; University of Illinois; 2 weeks; one physician.
3. Course in electric shock; Oregon State Hospital; 2 weeks; one physician.
4. Course in eye and ear diseases, New York Eye and Ear Infirmary, New York City, N. Y.; 1 month; one physician.
5. Course in maxillo facial surgery; Mayo Clinic; 3 months; two physicians; two dentists.
6. Course in military neuropsychiatric; Masen General Hospital, Brentwood, Long Island, N. Y.; 6 weeks 17 medical officers.
7. Course in neurology; clinical neurology; Mayo Clinic; 3 months; one physician.
8. Graduate course in otology, rhinology, and laryngology; University of Cincinnati; 1 week; one physician.
9. Course in oral surgery; Hines Facility; 1 month; six dentists.
10. Course in pathology; Hines Facility; 3 months; one physician.
11. Course in physical medicine and rehabilitation; Mayo Clinic, Rochester, Minn.; 12 weeks; 10 medical officers (including 1 week at University of Minnesota for instruction in the Kenney treatment, and 1 week at Northwestern University for special instruction in physical medicine).
12. Course in diagnostic radiology and pathology, Hines Facility; 3 months; one physician.
13. Course in general surgery; Los Angeles Facility; 1 month; one physician.
14. Course in prefrontal lobotomy; George Washington University; 15 days; four physicians.

15. Course in psychoneurosis, La Grade General Hospital; 3 weeks; one medical officer.
16. Course in roentgenology; Hines Facility; 6 weeks; one medical officer.
17. Course in electric-shock therapy and electroencephalography; Northport Facility; 2 weeks; three medical officers.
18. Course in electroencephalography; Northport Facility; 2 weeks; one medical officer.
19. Course in electric-shock therapy; North Little Rock Facility; 2 weeks; one medical officer.
20. Courses in physical medicine, 12 weeks:  
     Mayo Clinic, Rochester, Minn.; six medical officers.  
     Northwestern University, Chicago; five medical officers.  
     Cornell University, New York City; four medical officers.
21. Course in roentgenology and pathology; Hines Facility; 18 weeks; one medical officer.
22. Course in subshock insulin treatment; Vaughan General Hospital, Hines; 10 days; one medical officer.
23. Course in tropical diseases; Walter Reed Hospital, 8 weeks; 10 medical officers.
24. Special training at Army amputation centers; 6 weeks:  
     Bushnell General Hospital, Brigham City, Utah, two medical officers.  
     Lawson General Hospital, Atlanta, Ga., two medical officers.  
     McCloskey General Hospital, Temple, Tex., two medical officers.  
     Percy Jones General Hospital, Battle Creek, Mich., two medical officers.  
     Walter Reed General Hospital, Washington, D. C., one medical officer.  
     England General Hospital, Atlantic City, N. J., two medical officers.
25. Course in rehabilitation of more severely disabled veteran; Institute for Crippled and Disabled, New York City; 3 weeks; 36 physicians, 18 physical therapy technicians, 17 psychiatric social workers, 15 occupational therapy technicians.

#### APPROVED COURSES FOR TRAINING IN THE NEAR FUTURE

26. Course in rehabilitation of deafened; Hoff General Hospital, Santa Barbara, Calif.; 5 days; one medical officer.
27. Course in anesthesiology; Mayo Clinic; 12 weeks; one medical officer.
28. Course in endoscopy; Temple University, Philadelphia, Pa.; 2 weeks; one medical officer.
29. Course in gastroscopy; Columbia University, New York City; 2 months; one medical officer.
30. Course in group therapy of psychoneurotics; Brooke General Hospital; Fort Sam Houston, Tex.; 10 days; one medical officer.
31. Course in physics and technology; Massachusetts Institute of Technology; Cambridge, Mass.; 10 weeks; one medical officer.
32. Clinical course in tuberculosis; Saranac Lake, N. Y.; 6 weeks; three medical officers.
33. Courses in the rehabilitation of the more severely disabled veterans will be continued at the Institute for the Crippled and Disabled until sufficient medical personnel have been trained to cover this phase of therapy.

MR. BENNETT. Are they still taking those courses at public expense?

DR. GRIFFITH. They are in uniform and we can order them for the time being.

MR. BENNETT. That is the present situation?

DR. GRIFFITH. That is all; there is no way of holding a man you have to his word and he can break it.

MR. AUCHINCLOSS. Where is the hospital in New York?

DR. GRIFFITH. I think it is at the Gardner General Hospital. The Army is giving a course in psychiatry by the professor of psychiatry from the city of New York and the Army has permitted us to send our people there.

MR. AUCHINCLOSS. What hospital?

DR. GRIFFITH. I think it is the Gardner Hospital, of Brooklyn. They are trying to adopt their new refresher courses and they are permitting us to send our men in. We have sent classes to Walter Reed

Hospital in tropical diseases and also in Chicago. We tried to cover all the tropical diseases. We have got them very well covered. We expect to make New Orleans one of our tropical-disease centers.

Mrs. ROGERS. When did you start these courses?

Dr. GRIFFITH. We have been doing it now for 2 years.

Mrs. ROGERS. What is your procedure of operation? Do you recommend directly to General Hines?

Dr. GRIFFITH. We know; we have got the records of the individual doctors and we know what our needs are. We know the doctor's training and we recommend that individual for a course and the Administrator approves it.

Mrs. ROGERS. In all procedure do you recommend directly to General Hines?

Dr. GRIFFITH. Yes.

Mrs. ROGERS. And he approves it?

Dr. GRIFFITH. Of course, we will tell him very definitely we want to put so-and-so in post-graduate courses and do we have the authority, and he grants it.

Mrs. ROGERS. Without going through any other channels it goes direct to General Hines?

Dr. GRIFFITH. It goes to General Hines direct and he forwards it and never disapproves it. It is automatic.

Mrs. ROGERS. Do you recommend where the hospital beds are needed?

Dr. GRIFFITH. Do I recommend where the hospital beds are needed?

Mrs. ROGERS. Are you consulted?

Dr. GRIFFITH. Colonel Ijams has construction, supply, and medicine, and back some time ago he asked each of us to give an over-all plan for the duration of the war, future plans, analysis, and summary and materials needed, in response to a request from the Administrator. We all made recommendations to Colonel Ijams and Colonel Ijams consolidated and sent them on to the Administrator and Federal Board.

Mrs. ROGERS. Were your recommendations carried out?

Dr. GRIFFITH. A lot of them were not. A lot of them were not completed and are not ready yet.

I have this report which was submitted to Colonel Ijams, Assistant Administrator, covering future planning—analysis and summary of material submitted in response to memorandum of September 12, 1942, on this subject and further development of this subject. I also have a tabulation of the personnel needed for the additional beds.

Chairman RANKIN. Without objection they may be inserted at this point.

(The report and data above referred to are as follows:)

To: The Medical director.

From: Colonel Ijams, Assistant Administrator.

Subject: (a) Future planning—Analysis and summary of material submitted in response to memorandum of September 12, 1942, on this subject.

(b) Further development of the subject.

APRIL 3, 1943.

Reference is made to your penned note "Since this memo was written the hospital bill has been approved. This will necessitate certain changes in your memo. I suggest they be made so that the memo will refer only to the current situation when I send it to the Administrator. Also I would like you to coordinate your recommendations on construction with Colonel Tripp so that these recommendations will have the support of all services interested in that part of our problem. In this memo you are making one recommendation which changes completely what we have done in the past—I refer to the location of NP hospitals.



Because this is such a complete reversal of past action your reasons for the recommendation should be fully substantiated" dated March 20, 1943, attached to my memorandum to you of March 10, 1943, on the above subjects.

In accordance with your request I have reviewed the subject matter contained in my memorandum of March 10, 1943, in the light of the approval by the President on March 17, 1943, of Public Law 10, Seventy-eighth Congress, making changes where required, in order that my concept of future planning will be reflected by the current situation.

It is noted the Administrator desires supplementary data which is to give, as specifically as possible:

(1) The kind and amount of services we may be expected to provide in connection with each activity to be administered by the Veterans' Administration and

(2) What we will need to render any such service, having special regard to the effects of the actual and potential increase in work load and consequent expansion of the activities upon personnel, organization, equipment, space, construction, administrative policy and procedure affecting each group of service activities and the appropriations to cover all of these matters.

He requests further that the data be so presented as to separate the problems requiring planning into some such categories as the following:

(a) Those matters for which the needs are or will be definitely foreseeable, but for which the necessary means can be provided principally by developing now such measures of administrative policy and procedure as do not involve the consideration of great additional expenditures.

(b) Those matters which inevitably involve primarily a great expansion of the activities to an extent not definitely foreseeable, but obviously necessitating the providing of means which will require expenditures on such a scale that they must be the subject of very special planning with regard to both the possibility of sudden increase in load and of loads covering long periods.

Such supplemental information to my memorandum of September 28, 1942, on the subject Future Planning is submitted herewith insofar as possible in the order and manner as requested:

# 1. KIND AND AMOUNT OF SERVICES

So long as the present World War II is in progress the new potential beneficiaries of the Veterans' Administration requiring consideration by the Medical and Hospital Service will be confined, for all practical purposes, to those individuals who are being discharged by CDD or medical survey from the Army, the Navy, the Marine Corps, and the Coast Guard and their auxiliaries, irrespective of line of duty status on discharge.

On demobilization the potential load of our beneficiaries will increase in a comparatively few months by leaps and bounds to almost astronomical figures, because all individuals discharged will immediately become potential beneficiaries, if we are to judge from our experience after World War I; which this demobilization will take place cannot now be predicted. Accordingly, if our study is to be specific our plans will need be confined primarily to our present potential load of beneficiaries currently being discharged from the armed services.

The latest Estimates of Disability Discharges from the Army, covering the fiscal years 1943-44, submitted by the Surgeon General's office, January 5, 1943, follow:

## CDD's, total (irrespective of LOD)

Type	Fiscal year 1943		Fiscal year 1944	
	Total	Number requiring hospitalization	Total	Number requiring hospitalization
General medical and surgical.....	40,815	8,163	49,885	9,977
Tuberculosis.....	3,240	1,620	3,966	1,880
Neuropsychiatric.....	23,445	7,327	28,655	8,955
(1) Psychotic.....	(3,751)	(3,751)	(4,585)	(4,585)
(2) Nonpsychotic.....	(19,694)	(3,576)	(24,070)	(4,370)
Total.....	67,500	17,110	83,500	20,812

The estimated strength of the Army, according to confidential information from the Vital Records Division, Surgeon General's Office, is expected to be a mean of 4,500,000 for the fiscal year 1943; and for the fiscal year 1944 a mean of 5,500,000. The total CDD's, irrespective of line of duty for 1943 and 1944, will approximate 15 per thousand troop strength, of which 4 per thousand will require hospitalization by the Veterans' Administration. The ratio of hospitalized cases will comprise 2.3 general medical; 2.2 neuropsychiatric, and 0.5 tuberculous, for each five (5) cases admitted, or 1.84 general medical and surgical; 1.76 neuropsychiatric and 0.5 tuberculous patients requiring hospitalization by the Veterans' Administration per 1,000 troop strength of the Army. This ratio has been computed from estimates furnished by the Office of the Surgeon General of the Army. Essentially until demobilization begins the CDD's will comprise the bulk of the potential beneficiaries for hospitalization from the Army, other honorable discharges being of such little portent that for all practical purposes their inclusion may be disregarded. Consequently, we can expect 18,000 cases eligible for hospitalization during the balance of the year 1943 and an additional 22,000 individuals eligible in the fiscal year 1944, or a total of 40,000 beneficiaries from the Army alone by June 30, 1944.

The strength of the Navy at the end of the calendar year 1943 is expected to be 2,000,000, and in December 1944, 2,750,000, according to informal and confidential information from the Personnel Division of the Navy. Discharges by IS (medical survey) during World War I for the Navy averaged 50 per thousand, but for the present conflict, because of the nature of naval combat in this war in contrast to the last, it is estimated by the Surgeon General of the Navy that the discharge rate for disability will approximate 30 per thousand strength. Hospitalization will be required for about 10 per thousand strength. In 1943 hospital facilities will be necessary for 20,000 disabled naval personnel and in 1944 for 27,500 additional invalided from that service, or a total of 47,500 from the naval forces by the end of 1944.

The Personnel Unit of the Coast Guard informs me that for 1943 the mean strength of the Coast Guard is approximately 130,000 enlisted men, cadets, and officers. For 1944 it is estimated that the mean strength will be 175,500. Discharges for disability in 1942 were one-half of 1 percent mean strength, but because of the nature of operations now being carried on by the Coast Guard, it is expected this type of discharge will be granted 5 per thousand strength for 1943 and 1944. It is believed hospitalization will be necessary for 2 per thousand strength. On this basis, hospital beds will be required in 1943 for 260 disabled Coast Guard personnel and in 1944 for 340 such beneficiaries.

Information from the Personnel Division of the Marine Corps is to the effect that the mean strength of that corps for the fiscal year 1943 is estimated to be 300,000 officers and men and for 1944 will be approximately 375,000 officers, men, and cadets. Discharges for disability are comparable to that of the Navy, i. e., 30 per thousand strength and hospitalization will be required for about 10 per thousand strength.

Informal contact with the offices of the Surgeon General of the Army and Navy elicits the information that the mean strength of the various women's auxiliary forces, covered in Public Law 10, Seventy-eighth Congress, for the fiscal years 1943 and 1944, are expected to be as follows:

	1943	1944		1943	1944
WAVES .....	29,000	67,000	WAC .....	8,500	350,000
SPARS .....	2,400	11,000	Nurse Corps, Army.....	32,000	50,000
Marine Corps Women's Reserve .....	3,500	20,000	Total.....	80,000	506,500
Nurse Corps, Navy.....	5,000	8,000			

The discharges by medical survey for the Waves, Spars, Women's Reserve of the Marine Corps, and Nurses Corps of the Navy will average 28 per 1,000, according to the Surgeon General of the Navy, with 8 per 1,000 requiring hospitalization after discharge.

Ten per 1,000 strength of the Nurses Corps of the Army are expected to receive CDD's per year, of which 3 per 1,000, it is estimated, will require hospitalization.

The present standards required for enlistment in the Women's Army Auxiliary Corps have been lower than those required for members of the Nurses Corps

of the Army. For this reason, 15 per 1,000 troop strength will no doubt receive CDD's per year and of these about 5 per 1,000 troop strength will require hospitalization.

Many discharges from the Army, Navy, Marine Corps and Coast Guard subsequent to December 7, 1941, and prior to the beginning of the fiscal year 1943 (July 1, 1942), a period of a little over 6 months, which required hospitalization, have in the main already been absorbed into our hospital load as line of duty cases. The discharges for other reasons in the armed forces and for all reasons in the various women's auxiliary corps and nurses corps have been numerically small and therefore need not be covered in our present computation.

A tabulation of the approximate discharges for disability during the fiscal years 1943 and 1944 and the number it is estimated will require hospitalization by the Veterans' Administration follows:

*Disability discharges (irrespective of line of duty)*

	Fiscal year 1943		Fiscal year 1944	
	Total number	Requiring hospitalization	Total number	Requiring hospitalization
Army.....	67,500	18,000	82,500	22,000
Navy.....	60,000	20,000	82,500	27,500
Marine Corps.....	9,000	3,000	11,250	3,750
Coast Guard.....	650	200	850	340
Total (male).....	137,150	41,200	177,100	53,590
Auxiliaries:				
WACS.....	130	45	5,250	1,750
Nurse Corps, Army.....	230	100	450	150
WAVES.....	810	230	1,875	535
SPARS.....	70	20	300	90
Women's Reserve Marine Corps.....	100	30	500	160
Nurse Corps, Navy.....	140	40	240	45
Total (female).....	1,540	465	8,675	2,730
Grand total.....	138,690	41,725	185,775	56,320

To hospitalize these beneficiaries, should those previously discharged from the armed forces and their auxiliaries request hospitalization benefits promptly, in addition to those being currently discharged because of disability that requires hospitalization, and judging by the ratio of hospitalized line-of-duty cases being received from the Army approximately 2,400 general medical and surgical; 7,345 neuropsychiatric, and 2,080 tuberculosis beds will be necessary during the fiscal year 1943; while in 1944, 3,240 general medical and surgical; 9,515 neuropsychiatric and 2,820 tuberculosis beds will be required.

In 1943, 40 general medical and surgical; 89 neuropsychiatric and 25 tuberculosis beds; and in 1944, 160 general medical and surgical, 489 neuropsychiatric and 135 tuberculosis beds, that it is estimated will be required as a consequence of Public 10, Seventy-eighth Congress, will be occupied by female beneficiaries.

To hospitalize the male beneficiaries will necessitate in 1943 approximately 2,370 general medical and surgical; 7,265 neuropsychiatric and 2,055 tuberculosis beds; for 1944, 3,080 general medical and surgical; 9,435 neuropsychiatric and 2,685 tuberculosis beds.

The "beds unoccupied" report for all Veterans' Administration facilities as of February 28, 1943, showed the following available beds:

	Male	Female
General medical and surgical.....	3,737	44
Neuropsychiatric.....	1,264	8
Tuberculosis.....	476	11
Total.....	5,476	63



These beds are available for utilization but in many instances the facilities reporting unoccupied beds do not have the requisite personnel on duty to man the standard bed capacity of the facility for full utilization. At the present time the Veterans' Administration has 1,169 beds allocated in naval hospitals and 1,013 in marine hospitals. Should these services require full use of their beds it may be essential to remove our beneficiaries. Thus, taking into consideration our vacant beds, 1,860 additional general medical and surgical; 15,990 additional neuropsychiatric, and 4,420 additional tuberculosis beds will be necessary through presently authorized new construction or remodeling of existing buildings; additional construction not presently authorized; leasing of new facilities; transferring of existing Army, Navy, or Public Health Service hospitals to the Veterans' Administration or the procurement of bed service by contract with civilian institutions, if the hospital load materializes as anticipated as the result of Public Law 10, Seventy-eighth Congress.

Concerning out-patient activities, it is not expected there will be an unusual increase during the remainder of the fiscal year 1943 and perhaps no marked increase may be anticipated for the fiscal year 1944, unless there should be a termination of the war, with the resultant tremendous increase in the number of claims filed for disability pension. At the present time the majority of World War I claims are on a permanent basis, and reexaminations for disability compensation are limited.

It is understood that claims of these men now being discharged as a result of disability are being rated upon the clinical records submitted by the War and Navy Departments, and accordingly out-patient examinations on this class of beneficiaries will presupposedly not be in order, at least until 1 year following the date for the initial rating. Presumably most of these cases will be called for reexamination, inasmuch as at the present time they are represented by those suffering with chest or neuropsychiatric disabilities and are not represented by these ex-servicemen having a disability which may be initially rated as permanent.

Examinations to determine the need for hospital treatment or domiciliary care should not show an appreciable increase during the remainder of this fiscal year, or the fiscal year 1944, inasmuch as it is believed that the number essential in connection with applicants now being discharged from the armed forces will be counterbalanced to a great extent by the lack of applications from World War I veterans who are now employed, and are not seeking treatment or care, except when absolutely necessary.

At a later date the need for increased purchase of artificial arms, legs, and various types of prosthetic appliances will materialize.

The Veterans' Administration will be called upon to care for a number of beneficiaries who are casualties of the present war and who have suffered gunshot wounds and other injuries of the face and jaw, which will require the training of a number of dental and medical officers in oral and plastic surgery. The treatment of recent combat injuries will also necessitate more intensive application of reconstruction therapy at such time as World War II beneficiaries are hospitalized in appreciable numbers.

There is an immediate need for a better method of observation, classification, and rendition of intensive treatment of the recent psychoses. The psychotic cases received from the present armed forces should not be sent immediately to our present facilities. A method of treatment, observation, study, and classification similar to that adopted by the more advanced States, such as New York, Massachusetts, Illinois, Michigan, and Wisconsin should be adopted. Neuropsychiatric centers should be constructed, separate from and independent of our present facilities. These should be located in metropolitan areas having large medical centers, such as Boston, New York, Philadelphia, St. Louis, and San Francisco.

Psychoses which have developed in the immediate past, particularly in the World War II group, should be sent to these centers for study and intensive treatment; there the recoverable cases may be returned to their community and those cases whose psychiatric condition will be chronic should be transferred to our present neuropsychiatric hospitals located in suburban or rural areas, in environment more conducive to their prolonged care, where unlimited outdoor recreation and physical therapy are available.

A definite need for a perpetual survey of all our neuropsychiatric patients for pulmonary tuberculosis exists at this time. The recent mass survey at Northport

indicated that while only 2.5 percent of the hospital population was known to have pulmonary tuberculosis, an additional 2.5 percent was found to be active but unrecognized by clinical methods. This continuous survey can be made with mobile units, similar to the one developed at Northport and those which are being used by the United States Public Health Service. The treatment of psychotic patients with pulmonary tuberculosis in our hospitals must be improved. The manner in which we are now caring for these cases is unsatisfactory. They are being treated in small units in our neuropsychiatric hospitals without, in many instances, the benefit of consultation by physicians trained in phthisiology. In these small units many patients have never received the application of collapse therapy and particularly chest surgery. It may be well to point out that due to our handling of these patients in the past, our knowledge of methods of treatment of tuberculosis and the results to be expected for the treatment of this condition in psychotic patients is not well established. At the present time we have approximately 800 neuropsychiatric tuberculous patients hospitalized in small units on special wards in 23 of our neuropsychiatric facilities with a ward capacity of from 8 to 83 beds. The average bed capacity of these small units is 35. If the survey at Northport and similar surveys in certain State hospitals which show about 5 percent of the patient population with active tuberculosis are taken as a guide, we may anticipate from 1,600 to 1,800 tuberculous patients among the veteran neuropsychiatric population presently hospitalized, without regard for any new cases to be received from the present armed forces.

## 2. REQUIREMENTS TO RENDER SUCH SERVICE

Having special regard to the effects of the actual and potential increase in work load and consequent expansion of the activities upon personnel, organization, equipment, space, construction, administrative policy, and procedure, the following data are submitted:

(a) THOSE MATTERS FOR WHICH THE NEEDS ARE OR WILL BE DEFINITELY FORESEEABLE, BUT FOR WHICH THE NECESSARY MEANS CAN BE PROVIDED PRINCIPALLY BY DEVELOPING NOW SUCH MEASURES OF ADMINISTRATIVE POLICY AND PROCEDURE AS DO NOT INVOLVE THE CONSIDERATION OF GREAT ADDITIONAL EXPENDITURE

### *I. Personnel*

The attached chart covers the estimated additional new authorized positions for medical personnel in the field which will be required on the basis of needed beds for hospital care of all discharged veterans, irrespective of line of duty status or service-connected disabilities. These estimates do not include personnel for the two new general medical and surgical hospitals to be opened during the calendar year 1943 at Fort Howard, Md., and West Roxbury, Mass., as such estimates have previously been submitted.

## Personnel for additional beds

Designation	Grade	On basis of L. O. D. cases		On basis of Rankin bill (not in L. O. D.)	
		Fiscal year 1943		Fiscal year 1944	
		Total	Cost	Additional total	Additional cost
Senior medical officer.....	P&S-5	0	0	0	0
Medical officer.....	P&S-4	6	\$22,800	84	\$319,200
Associate medical officer.....	P&S-3	0	0	0	0
Psychiatric social worker.....	SP-C	3	6,000	0	0
Head nurse.....	SP-6	0	0	0	0
Nurse.....	SP-5	14	25,200	35	63,000
Chief dietitian.....	SP-7	0	0	0	0
Head dietitian.....	SP-6	0	0	0	0
Dietitian.....	SP-5	0	0	0	0
Dentist.....	P&S-4	0	0	0	0
Associate dentists.....	P&S-3	0	0	0	0
Dental mechanic.....	SP-6	0	0	0	0
Dental assistants.....	SP-3	0	0	0	0
Occupational therapy aide.....	SP-5	0	0	0	0
Occupational therapy junior aide.....	SP-4	0	0	10	18,000
Occupational therapy attendants.....	SP-5	0	0	8	12,960
Physiotherapy aides.....	SP-5	0	0	7	10,080
Chief, physiotherapy aide.....	SP-6	0	0	6	10,800
Physiotherapy junior aide.....	SP-4	0	0	0	0
Librarian.....	SP-5	0	0	4	6,480
Assistant librarian.....	SP-4	0	0	0	0
Chief librarian.....	P&S-1	0	0	0	0
Do.....	P&S-2	0	0	3	3,240
Physical director.....	SP-6	0	0	0	0
Physiotherapy attendants.....	SP-3	0	0	0	0
Assistant laboratorian in roentgenology.....	SP-4	0	0	0	0
Assistant laboratorian in bacteriology.....	SP-4	0	0	0	0
Cook, B.....	CPC-4	0	0	13	10,500
Mess attendant.....	SP-2	0	0	61	87,840
Do.....	SP-1	0	0	50	60,000
Head attendant.....	SP-3	4	6,480	9	14,580
Do.....	SP-3	40	57,680	99	160,380
Hospital attendant.....	SP-2	28	36,960	176	87,120
Laboratorian in roentgenology.....	SP-6	0	0	0	0
Laboratorian in bacteriology.....	SP-6	0	0	5	10,000
Senior stenographer.....	CAF-2	2	2,880	0	0
Head waiter.....	SP-3	0	0	10	14,400
Total.....		97	158,000	763	1,302,940
				353	738,600
				2,661	4,478,300



*For out-patient activities.*—The Denver regional office has requested the establishment of a full-time position of psychiatric social worker, SP-6, \$2,000, which is needed during the present fiscal year. In addition, for the fiscal year 1944, for medical purposes in out-patient work, there should be 1 social worker for each 100 claimants examined on an out-patient status at each facility per month, on the assumption that 1 out of every 10 will require full social investigations; that 2 others among every 10 claimants, i. e., 20 cases, will require social work to enable them to carry through the medical recommendations that will help them avoid aggravation of the disease and later hospitalization.

*For pension purposes.*—It is estimated that 1 out of every 10 neuropsychiatric claims filed will require a full social investigation. A total of 10 such cases can be handled a month. All neuropsychiatric claimants with over 10 percent rating require an interim social investigation report prior to reexamination and re-rating. About 20 such cases a month could be handled, together with the 10 full social investigations outlined above, or a total case load of 30 a month. The exact number required will depend on the case load which is as yet undetermined.

With the passage of Public 10, a very marked increase in dental activities must be anticipated in the furnishing of treatment to hospitalized beneficiaries and the increase in out-patient dental activities, both in respect to treatment and applications for service connection for dental disabilities. A number of regional offices which at one time had on duty a dental officer who acted as the dental member of the rating board, and which office operated the dental clinic, were in existence. More recently it has been found to be more economical to detail a dentist from another station periodically to handle the dental adjudicative and administrative activities, and refer examinations and treatment to designated dentists on a fee basis. With the anticipated increase in applications for treatment this system will no longer be economical, and it will no doubt be necessary to establish dental clinics in these offices and assign dental personnel for their operation. It is anticipated that this particular phase of dental activities will require in 1944:

Dentists, P&S-4.....	8
Dental mechanics, SP-6.....	4
Dental assistants, SP-3.....	8

*In central office.*—The position of assistant superintendent of nurses is necessary at once if the nursing subdivision is to adequately handle the problems confronting it. This subdivision is responsible for the planning of future nursing staff education and orientation courses and directing nursing activities in order to maintain a high standard of nursing care to patients throughout the hospitals of the Veterans' Administration. In order that the Administration may be represented, it is necessary at times for the superintendent of nurses to be absent from her office in attendance at various meetings of a national character. Interviewing applicants for nursing positions, discussing nursing problems and outlining policies all are time consuming and represent time from office duties, which cause necessary delay in appointments, transfers, etc., that could be expedited by the assignment of an assistant superintendent, P&S-3, \$3,200 per annum, who is familiar with nursing problems in the field.

Supplementing my previous recommendation for more frequent field supervision of medical activities in the field service, there should be assigned to the Medical and Hospital Service for systematic check of the adequacy of hospital diets during the food rationing period and for the maintenance of proper dietetic standards, a position of supervising dietitian, P&S-3, \$3,200 per annum, with an additional estimated cost of approximately \$1,800 for travel and per diem expenses.

One assistant to the Chief of the Social Work Section, P&S-2, \$2,600 per annum, is needed to help provide for continuous field supervision; interpretations to managers, physicians and others of how to use social work effectively as a factor in medical examinations and treatment, and to standardize practices on a professional level; supplementation of efforts of the Civil Service Commission in recruiting staff; development of the collaboration of schools of social work in establishing training centers for social-work students at certain stations; and the carrying through of "refresher courses" for older employees who have been on the staff for several years.

An additional stenographer, CAF-3, \$1,620 per annum, will be required in the Social Work Section, central office, beginning with the fiscal year 1944, to handle increased correspondence with field stations regarding policies; increased num-

bers of requests from central office rating agencies for social investigations, (Veterans' Claims Service, Dependent's Claims Service, Insurance Claims Council and the Board of Appeals); increased numbers of requests from field stations for summaries of medical and social data in the case files held in central office; and increased social work in connection with personnel selection and assignments.

It is quite possible that there may be a need for increased personnel in the unit formerly designated as the Foreign and Insular Division. It may be reasonably assumed that there are many individuals now serving the Allied Forces who are residents of the United States, and will return to the United States upon their separation from the service, or upon termination of the war. No estimate of this possible increased load may be given at this time.

There are 13 stenographic and 3 clerical positions vacant in the Medical and Hospital Service in central office. Three of these stenographic vacancies are grade CAF-2 positions in the Service Unit. In addition, there are 2 CAF-2 stenographic positions in the unit which are filled. It is felt the 5 positions (vacant and filled) should be in grade CAF-3. At one time these positions were in grade CAF-3, but were changed to grade CAF-2 in connection with the economy program. Recommendation is being made in a separate memorandum in the Director of Personnel that these 5 positions be restored to grade CAF-3. This request is being made due to the fact that the grade CAF-2 stenographers in the Service Unit are performing the same type of work as the grade CAF-3 stenographers in this unit and should be properly classified in grade CAF-3.

## *II. Organization, administrative policy and procedure and their general relation to various activities*

The shortage of medical personnel is becoming more acute. While the inauguration of the 48-hour week has alleviated temporarily the critical situation in some classifications, particularly the nursing and attendant groups, it is evident that in most categories we are "scraping the bottom of the barrel."

The procurement of associate physicians from civil-service registers has, for all practical purposes, terminated at least for the duration of the war. To illustrate—it was expected to place from 40 to 50 associate physicians in training January 1, 1943, but only six were found to be available from civil service registers and assigned to duty. A similar situation occurred February 1st and the March 1st class of new associate physicians, when again it was hoped to have an enrollment of 40 or 50, will, if all who are under orders to report, actually amount to eight. January civil-service registers were exhausted for grade 4 physicians in the several specialties and 2 were actually assigned to training at Hines. In an effort to obtain a group of medical officers, grade P&S-4 physicians, representing the specialties from civil-service registers for a March 1st course at Hines, actually one is under orders to report. This indicates that the United States Civil Service Commission as a source of medical officer material has become practically arid.

The loss of physicians to the armed forces has become a critical problem. Up to June 9, 1942, 253 physicians and dentists were released, upon request, to the armed forces. Even though approximately 1,100 Veterans' Administration medical and dental officers have been commissioned in the Army of the United States and held on an inactive status in the Veterans' Administration, a considerable number have not found the status acceptable and have left the service, giving up the commissions granted them as members of the Veterans' Administration in order that they might obtain new commissions in the United States Army, and then enter active duty in the Army. Up to and including February 25, 1943, 90 medical and dental officers have resigned to enter the armed forces. In addition to this there were 155 additional resignations for various reasons, 18 deaths, and 50 retirements. Therefore, unless the Veterans' Administration should become an integral part of the War Department so that this service would become eligible to receive medical officers under the same status as the United States Army, the outlook for the future for the Medical and Hospital Service appears definitely gloomy, particularly so with the proposed expense of facilities and expected great increment of patient load.

Furthermore, 80 percent of the enrollment of the A class medical schools of the United States is being taken over by the Army and Navy for training of enlisted personnel in medicine. The remaining 20 percent of the enrollment will probably consist of women and those men who are in such physical condition that they may not be taken by the armed forces.



Drastic administrative action looking towards the development of at least a reasonable source of qualified medical officers for service with the Veterans' Administration in a status premitting of their continued service with this organization is believed necessary.

There are at present a number of vacancies at field stations in the various centralized subprofessional groups, especially the nursing, dietetic, social service, and library classifications, in which considerable difficulty is being experienced in effecting replacements. Approximately 339 nurse, 10 librarian, 16 dietitian and 7 social worker positions are now vacant and many of these authorized positions have been in this status for a number of months.

There are two plans which may assist in relieving the present shortage of graduate nurses in our hospitals.

*Plan I.*—The proposed plan for a Victory Student Nurse Corps has been submitted to the Budget Bureau. Should this plan be approved and the Veterans' Administration decide to utilize a portion of these third year cadet students for the last 6 months of their training it would be necessary to establish additional supervisory positions. No definite number of supervisory positions has been established in this plan. The parent school would have to be assured their students would receive adequate supervision, and the hospital that accepts the students would be responsible for maintenance of students. The stipend of \$30 per month has been approved by the committee, however, no definite decision has been made as to who should pay the stipend—the United States Public Health Service who sponsored this plan, or the hospital utilizing the cadet students.

*Plan II.*—A plan for application has been discussed by Duquesne University at Pittsburgh, Pa., whereby the Administration would take their second year junior students for assignment at the Pittsburgh Facility for 4 months training in general medicine and surgery. Under this suggested plan, the Administration furnishes maintenance plus \$1 per year for each student. One instructor at \$2,600 per annum and one supervisor at \$2,300 would be required by the parent school in order that their students meet State training requirements. The university would supply from 10 to 20 students each 4 months, the exact number to be decided later should the plan be approved. The facility at Hines, Ill., has also requested authority to train student nurses from a nearby hospital.

If either or both of these plans should materialize, it might prove advantageous to apply their principles to other facilities, especially the Bronx, Atlanta, Bay Pines, Jefferson Barracks, Los Angeles, and Portland.

The use of nutrition aides in general medical and surgical facilities, when available, during the national emergency is suggested as a partial solution to problems resulting from labor shortages in the dietetic departments, provided the 60 day trial at the Hines Facility, recently approved by the Administrator, warrants the procedure at other stations. During the fiscal year 1944, it is estimated that the services of approximately 500 nutrition aides at \$1 per annum, plus meals and laundering of uniforms worn on duty, could be utilized to advantage.

To provide a reservoir of qualified dietitians to fill vacancies in the entrance grade, it is considered feasible to give 6 months of hospital training in Veterans' Administration hospitals to dietitians who meet civil-service requirements in education, after such individuals have taken 6 months of approved student dietitian training in civilian hospitals, under the same plan operated by the War Department.

To retain experienced service dietitians and to interest well qualified ones in accepting appointment in Veterans' Administration hospitals, early consideration should be given to the reclassification of dietitians who are now in grades SP-6, SP-7, and SP-8, in the first three grades of the professional and scientific service.

Plans should be made to develop at least eight stations (West Roxbury, Bronx, Northport, Pittsburgh, Hines, Jefferson Barracks, New Orleans, and Los Angeles), a set-up which will warrant the placement of students by schools of social work for their field training. This will help increase the interest of schools in the Veterans' Administration, develop a potential source of future employees after their graduation, as well as develop the high standard of work which teaching responsibility tends to stimulate and which will be reflected throughout the service.

It should be our established policy to have two grades of social work positions in the field; namely, positions under supervision and positions at the head of the department, whether there are assistants or not. The position of social worker



under supervision should be SP-7, \$2,300 per annum and the position of chief social worker, P&S-2, \$2,600 per annum. These salaries are more in line with those of other reputable organizations than is our present entrance salary of SP-6, \$2,000 per annum. For the one grade position of psychiatric social worker, one Federal Agency—the War Relocation Authority, is offering \$3,200 and \$2,600 to medical social workers. The American Red Cross offers \$3,200 and a number of our staff have gone to that agency. The New York State system, it is understood, pays its chief social workers from \$2,760 to \$3,300. The American Association of Psychiatric Social Workers reports that a recent study of its membership (who represent precisely the type of training which the Veterans' Administration needs to meet its responsibilities), shows that the great majority are available for positions only in the \$3,000 to \$6,000 range.

It is anticipated that the American Library Association will place before certain of the accredited library schools the need for greater emphasis on the opportunities for their graduates in the hospital library field and encourage the introduction into their curricula of courses to prepare librarians for this work. With this effort the Veterans' Administration should fully cooperate in the interest of recruitment and if possible should permit certain of its well-equipped libraries to be used for practice training for selected students if so requested, this to be without expense to the Veterans' Administration.

In view of the increasing difficulties experienced in securing suitable librarians to fill our SP-4 grade positions in tuberculosis hospitals, where appointees must be at least 30 years of age, and in neuropsychiatric hospitals, where more specialized background and experience are required, it is believed that the grade should be abolished in these hospitals and grade SP-5 substituted for it. Assistants in general medical and surgical hospitals may remain in grade SP-4. It is considered wise administrative procedure instead of using grade SP-6 for chief librarians, to substitute grade P&S-1 and to reassign all chief librarians now in grade SP-6 to grade P&S-1.

The changes in grade and additional library positions which may be required in 1944 are indicated below:

No.	Grade changes recommended	Cost
10	SP-4 to SP-5.....	\$1,800
27	SP-6 to P&S-1.....	(1)
59	SP-5 to P&S-1.....	11,800
21	New, SP-5.....	37,800
5	New, SP-4.....	8,100
2	New, P&S-1.....	4,000
7	SP-6 (P&S-1) P&S-2.....	4,200
	Total.....	67,700

<sup>1</sup> No funds required.

The new positions at the Fort Howard, Md., and West Roxbury, Mass., facilities are not included in these estimates, except as recommended changes in grade require. The sum of \$400 has been included to cover the two changes from SP-5 to P&S-1.

With the increasing load of neuropsychiatric patients and the lack of experienced librarians for this type of work, it may be necessary to consider establishing additional training positions at Augusta, Ga., and at Palo Alto, Calif. The expense of this is covered in the outline of position changes.

No special change in medical administrative policy or procedure will be necessary in connection with the increased hospital load in the general medical and surgical or the tuberculosis groups of hospitals.

There are two factors regarding medical administration of neuropsychiatric hospital which should have consideration.

Promotion of medical personnel beyond grade P&S-5 is in the administrative field rather than the clinical. In giving consideration to the promotion of grade 5 physicians to clinical directors and chief medical officers, their administrative ability is given great weight and necessarily so, because they form the reservoir from which managers are chosen. This is not the only reason however, because the clinical director's position is primarily administrative at present. As our neuropsychiatric hospitals have grown in size, the charts of organization have not kept pace. Where our small hospitals of 300 to 400 beds had one clinical

director and two or three grade 5 physicians and have grown to 1,200 to 1,500 to 2,000 beds, they still have but one clinical director and only three or four grade 5 physicians. Administrative detail has increased rather than diminished and as a result, the clinical director or chief medical officer is chained to his desk by this mass of administrative detail. When a neuropsychiatric hospital increases in bed capacity above 1,000 clinical supervision diminishes in direct proportion to subsequent bed increases, all other factors being equal. Provision therefore should be made for promotions in grade for clinicians proportionate to promotion for medical administrative ability. In no other manner can we give our clinical work and our patients the medical supervision and treatment which they need.

In addition, the clinical director in hospitals of 1,000 beds or over should be given assistance in medical administrative work; be entirely freed from the detail of administrative matters and permitted to devote the greater percentage of his time to clinical medicine.

It is recommended therefore that the position of clinical director be reallocated to grade P&S-7 in neuropsychiatric hospitals of 1,000 beds or over and in neuropsychiatric centers, when and if they are established, and that the present position of grade P&S 6 in neuropsychiatric hospitals of 1,000 beds or over be established for a medical administrative officer and assistant to the clinical director. This would result in the establishment of 19 additional positions grade P&S-7 at an expense of \$125,500 per annum.

The position of chief social worker, SP-8 at the Bronx, Hines, and Los Angeles facilities should be established by the reclassification of one position of social worker SP-6 at each facility at a combined cost of \$1,100 per annum. There should be attached to the out-patient department at stations having domiciliary beds, 1 social worker for each 1,000 members domiciled, to promote their rehabilitation and discharges from the home.

Mobile X-ray units for the perpetual survey of all patients in our neuropsychiatric hospitals for pulmonary tuberculosis are definitely needed. These units may be purchased for approximately \$4,000 each and we should have two such units, one for use east of the Mississippi, the other for use west of the Mississippi. The truck or automobile to house and transport each unit would cost about \$1,000, making a total cost of the mobile units approximately \$10,000. Four technicians, two grade SP-7 laboratorians, and two grade SP-6 laboratorians; two laboratorians for each unit, at a salary cost of \$8,600 per annum would be required. Operation, maintenance, with travel and per diem for the technicians is estimated at \$12,000 per annum. The total expense of this survey would entail an expenditure of about \$30,000 the first year and approximately \$20,000 in succeeding years.

During the fiscal year need will materialize for additional supervisory personnel in recreation and physical exercise, particularly in our neuropsychiatric hospitals, the extent of which cannot be accurately determined at this time.

A number of positions of dental personnel have been abolished due partly to the operation of the 48-hour week, but more particularly to the low utilization of beds. Several of these positions will probably be required during this fiscal year.

Dentist P&S 4.....	1
Associate dentists P&S-3.....	2
Dental assistant SP-3.....	1
The remainder will be required during 1944:	
Associate dentists P&S-3.....	7
Dental mechanics SP-6.....	5
Dental assistant SP-3.....	1

### III. Space

Additional hospital bed space will be required during the fiscal years 1943 and 1944. In general medical and surgical this can be met after the utilization of vacant beds, by change in space for dayrooms, etc., to bed space. In the tuberculosis hospitals, plans to remodel existing ward buildings in 4 tuberculosis hospitals augmented by renovating of ward space in the tuberculosis departments of 2 general hospitals will increase the bed capacity for tuberculous patients by approximately 665 beds. These projects are expected to be completed as soon as possible and should take care of the bed situation for tuberculous patients until the end of the calendar year 1943.

New increments of neuropsychiatric patients will have to be absorbed during the current year by present vacant beds and by crowding existing space. As bed capacity increases, a certain increase of both administrative and clinical space



will be required. The amount of this increase depends on the particular hospital and the need when it develops will sometimes require additional construction, while in other instances only limited structural changes will be needed. Until a more detailed construction program is outlined, this cannot be developed further.

For occupational therapy activities in all types of hospitals, approximately 18,000 square feet of additional space should be furnished by conversion of existing space, during the remainder of this fiscal year and for the fiscal year 1944. It will be required for full bed utilization or to care for contemplated new construction in the 1943 or 1944 fiscal years.

For dental activities it is believed that space now provided will be adequate for the fiscal year 1943 and probably for the fiscal year 1944. However, for the fiscal year 1944, it may be necessary to establish eight small dental clinics in certain regional offices where dental clinics are not now set up. No reasonably accurate estimate can be given regarding additional space required or construction changes until there is more detailed information available as to the location of stations at which additional bed capacity will be made available.

#### IV. Construction

For 1944 we should plan for at least 3 of the 5 200-bed hospitals for neuropsychiatric centers. It is doubted if such hospitals can be constructed for less than \$7,000 per bed, or \$1,400,000 each, or a total expense of \$4,200,000.

At least 5 of the 150-bed tuberculosis units in neuropsychiatric hospitals should be planned for 1944. These will cost approximately \$375,000, or \$1,775,000.

The above construction will provide 1,350 beds, with 1,124 beds planned for Marion, Ind.; Canandaigua, N. Y.; St. Cloud Minn.; Coatesville, Pa.; Bedford, Mass., and Tuskegee, Ala.; this leaves with those noted above a need for 12,245 beds to care for the estimated 1943-44 load of neuropsychiatric cases. This need will exist before construction can possibly be completed.

It is desired to stress the fact that the need for neuropsychiatric centers and for neuropsychiatric tuberculosis units is immediate and irrespective of need for haste, the forthwith construction of neuropsychiatric centers should not be interfered with. Upon this decision will depend our entire future policy with regard to the care and treatment of neuropsychiatric cases, as well as the standing of the Veterans' Administration in the medical world in this regard. These units are needed for the treatment of recent cases of psychoses and these recent cases are now with us. They cannot be as adequately treated in our existing facilities as in the centers such as have been described. If the total number of neuropsychiatric centers and neuropsychiatric tuberculosis units cannot be planned for 1944, then an attempt should be made to complete them in 1945.

Approximately 100 additional beds (80 neuropsychiatric and 20 tuberculosis) in 1943 and 775 beds (160 general, 480 neuropsychiatric and 135 tuberculosis) in 1944 will be required to hospitalize female beneficiaries granted hospital benefits by Public No. 10. Due to the lack of adequate facilities in Veterans' Administration hospitals for the care of female patients, the majority of such claimants will of necessity have to be hospitalized in contract hospitals until such a time as new construction or the remodeling of existing space for male beneficiaries is undertaken for this class of patient. Some of the load of female patients can be absorbed in existing facilities without structural changes by the redesignation of male beds to female beds, but for the most part this will not prove satisfactory.

When social work office space is planned in any of our facilities, there should be sufficient room provided to permit the social workers to be grouped in offices near the chief medical officer with easy access on the part of the physicians, patients and their relatives. There should be one or more separate small light offices also to provide for private conferences with patients and relatives, for dictating reports and correspondence.

#### V. Appropriations for expansion of activities, equipment, and maintenance, etc.

Additional appropriations for personnel needs for the balance of the fiscal year 1943 and the fiscal year 1944 are outlined in the attached chart. The totals are as follows:

Fiscal year 1943, 455 positions.....	\$910, 220
Fiscal year 1944, 7,122 positions.....	11, 186, 640

The amount of expenditures which it is estimated will be required for equipment only for additional beds over and above vacant beds available February 20,



1943, using the average cost for tuberculosis and general medical and surgical beds as \$250 per bed and for neuropsychiatric beds at \$150 per bed is outlined below:

	Until end of fiscal year 1944
4,420 tuberculosis beds-----	\$1, 105, 000
1,860 general medical and surgical beds-----	465, 000
15,990 neuropsychiatric beds-----	2, 398, 500
Total-----	3, 968, 500

Funds for supplies, including subsistence, are covered in operating expenses which is tabulated below:

*Operating expenses, including personnel and maintenance costs of the additional beds required for 1943 and 1944 will approximate*

	Fiscal year 1943	Fiscal year 1944
General medical and surgical (per diem \$5)-----	\$1, 080, 000	\$5, 913, 000
Tuberculosis (per diem \$5)-----	936, 000	5, 145, 000
Neuropsychiatric (per diem \$2.20)-----	1, 454, 310	7, 961, 745
Total-----	3, 470, 310	19, 019, 745

(B) THOSE MATTERS WHICH INEVITABLY INVOLVE PRIMARILY A GREAT EXPANSION OF ACTIVITIES TO AN EXTENT NOT DEFINITELY FORESEEABLE, BUT OBVIOUSLY NECESSITATING THE PROVIDING OF MEANS WHICH WILL REQUIRE EXPENDITURES ON SUCH A SCALE THAT THEY MUST BE THE SUBJECT OF VERY SPECIAL PLANNING WITH REGARD TO BOTH THE POSSIBILITY OF SUDDEN INCREASE IN LOAD AND LOADS COVERING LONG PERIODS

The present neuropsychiatric hospitals are located, constructed, and staffed as hospitals for the care of the chronically insane. These hospitals have for the most part met our needs during the past few years and with the peak load of neuropsychiatric cases from World War I having been reached, or in sight, no recommendations for these special neuropsychiatric centers would have been made if it were not for the great load of newly developed psychoses which we are to receive from World War II.

The experience of the most advanced States and of the medical profession has demonstrated the need and desirability of neuropsychiatric centers for the reception and intensive treatment of recent cases of the psychoses. These centers serve to screen recent psychoses under most favorable observation and under treatment by the best qualified personnel. Those who require special study and those who may recover under a reasonable period of intensive treatment are cared for here rather than in hospitals primarily equipped for the continued care of mental cases.

The location of these special neuropsychiatric hospitals in metropolitan areas places them near centers of ex-service population. Such locations permit us to obtain the services of consultants of national reputation. These hospitals will serve as diagnostic and research centers for neuropsychiatric disabilities. The location permits their use for teaching purposes by medical schools and permits affiliation with recognized schools of nursing, social service, and home economics. This close association with teaching institutions will assist the Administration in obtaining professional and subprofessional personnel with the highest qualifications.

The neuropsychiatric centers, conducted in this manner, will serve as training centers for our professional and subprofessional personnel and raise the standard of both personnel and the service in all of our neuropsychiatric hospitals.

The construction of these neuropsychiatric centers would in no way limit the rise and expansion of our present neuropsychiatric hospitals for cases needing continued care. It should be definitely understood when these neuropsychiatric centers are set up that they are, so far as treatment is concerned, for intensive therapy directed toward the psychotic condition which has developed in the immediate past and that regardless of outside pressure which may be applied to utilize these centers otherwise, they should not be expected to care for and

treat psychoses that have had their inception some years in the past or to continue therapy for cases which are chronic in character. This is distinctly the function of our present neuropsychiatric hospitals in suburban and rural areas.

In these centers there will be need for separate facilities for female beneficiaries of World War II who manifest acute psychosis.

It is suggested that five units be constructed and located at Boston, Philadelphia, St. Louis, New Orleans, and San Francisco. They should have approximately 200 beds each. These hospitals should take care of the reception, treatment, and classification of 6,000 patients per year. A typical chart of organization for each hospital follows:

**Psychologists (2):**

1 psychologist, P&S-3, \$3,200-----	3,200	
1 psychologist, P&S-2, \$2,600-----	2,600	
		5,800

**Medical technicians (6):**

1 pharmacist, P&S-1, \$2,000-----	2,000	
2 medical technicians, SP-6, \$2,000 each-----	4,000	
2 medical technicians, SP-6, \$1,800 each-----	3,600	
2 medical technicians, SP-4, \$1,620 each-----	3,240	
		12,840

**Medical clerical (18):**

1 CAF-5, \$2,000-----	2,000	
5 CAF-3, \$1,620 each-----	8,100	
9 CAF-2, \$1,440 each-----	12,960	
3 CAF-1, \$1,260 each-----	3,780	
		26,840

**Miscellaneous medical (9):**

2 barbers, CU-4, \$1,320 each-----	2,640	
1 housekeeper, CU-4, \$1,320-----	1,320	
6 maids, CU-2, \$1,080 each-----	6,480	
		10,440
<b>Grand total</b> -----		<b>394,560</b>

The operation of each center would cost approximately \$8 per diem, or about \$55,000 per year per hospital. Equipment would cost \$400 per bed, or \$180,000.

Ten units of 150 beds each should be constructed at present neuropsychiatric facilities for the care of neuropsychiatric tuberculous patients and be adequately staffed for such treatment. Four of these units should be designated as surgical collapse centers for pulmonary conditions in psychotic patients and be located where consultation in thoracic surgery is available. The location of these four units should preferably be as follows: Augusta, Ga.; Northport, Long Island, N. Y.; Downey, Ill.; Palo Alto, Calif.

The remaining six units to be located at Northampton, Mass.; Coatesville, Pa.; Chillicothe, Ohio; North Little Rock, Ark.; Fort Lyon, Colo.; Knoxville, Iowa.

These units would be staffed as follows:

1 medical officer, P&S-5, \$4,600-----	\$4,600	
4 medical officers, P&S-4, \$3,800 each-----	15,200	
2 nurses, SP-6, \$2,000 each-----	4,000	
20 nurses, SP-5, \$1,800 each-----	36,000	
1 hospital attendant, SP-3, \$1,440-----	1,440	
17 hospital attendants, SP-2, \$1,260 each-----	21,420	
12 hospital attendants, SP-1, \$1,020 each-----	12,240	
1 aide, psychotherapy, SP-5, \$1,800-----	1,800	
1 attendant, psychotherapy, SP-3, \$1,440-----	1,440	
1 aide, occupational therapy SP-5, \$1,800-----	1,800	
1 attendant, occupational therapy SP-3, \$1,440-----	1,440	
1 cook, CPC-4, \$1,320-----	1,320	
3 mess attendants, SP-2, \$1,260 each-----	3,780	
6 mess attendants, SP-1, \$1,020 each-----	6,120	
1 stenographer, CAF-2, \$1,440-----	1,440	
<b>Total</b> -----		<b>114,040</b>

Equipment for each unit would cost approximately \$37,500; operation should not exceed \$145,000 per year, or approximately \$2.70 per diem.

It is believed that the additional appropriations necessary for the 1,340 beds in neuropsychiatric centers and the neuropsychiatric-tuberculosis units have been covered in the above tabulations. For the 1,100 neuropsychiatric beds to be

provided at Marion, Canandaigua, St. Cloud, Coatesville, Bedford, and Tuskegee, construction of which will be completed sometime after the fiscal year 1944, it is estimated that approximately the following personnel will be needed:

11 physicians, grade P&S-4, \$3,800 each	\$41,800
44 nurses, SP-5, \$1,800 each	79,200
22 attendants, SP-4, \$1,620 each	35,640
119 attendants, SP-3, \$1,440 each	171,360
79 attendants, SP-2, \$1,260 each	99,540
7 aides, occupational therapy SP-5, \$1,800 each	12,600
5 aides, occupational therapy SP-4, \$1,620 each	9,720
1 aide, psychotherapy SP-5, \$1,800	1,800
1 aide, psychotherapy SP-4, \$1,620	1,620
7 cooks, CPC-4, \$1,320 each	9,340
19 mess attendants, SP-2, \$1,260 each	23,940
44 mess attendants, SP-1, \$1,020 each	44,880
7 clerical, CAF-2, \$1,440 each	10,080
Total	541,520

Equipment for these additional beds will cost approximately \$155. per bed, or \$170,500. Maintaining and operation approximately \$2 per diem, or \$802,000.

A teaching and research institute at which postgraduate training for physicians in the service and research activities could be centralized, is indicated. This institute should be placed in a large center of population in close proximity to medical schools and civilian medical institutes. The following is submitted as a breakdown of a tentative estimate of the cost of such an institute:

Physicians (19) :

1 physician, P&S-7, \$6,500	\$6,500
1 physician, P&S-6, \$5,600	5,600
6 physicians, P&S-5, \$4,600 each	27,600
8 physicians, P&S-4, \$3,800 each	30,400
3 physicians, P&S-3, \$3,200 each	9,600
	\$79,700

Nurses (35) :

1 nurse, SP-8, \$2,600	2,600
1 nurse, SP-7, \$2,300	2,300
6 nurses, SP-6, \$2,000 each	12,000
27 nurses, SP-5, \$1,800 each	48,600
	65,500

Attendants (85) :

1 attendant, SP-6, \$2,000	2,000
2 attendants, SP-5, \$1,800 each	3,600
4 attendants, SP-4, \$1,620 each	6,480
15 attendants, SP-3, \$1,440 each	21,600
36 attendants, SP-2, \$1,260 each	45,360
27 attendants, SP-1, \$1,020 each	27,540
	106,580

Dental (2) :

1 dentist, P&S 4, \$3,800	3,800
1 dental assistant, SP-3, \$1,440	1,440
	5,240

Dietetic department (27) :

1 dietitian, SP-7, \$2,300	2,300
1 dietitian, SP-5, \$1,800	1,800
1 chief cook, CPC, \$1,860	1,860
1 cook, A, CPC, \$1,500	1,500
1 cook, B, CPC, \$1,320	1,320
1 baker, CPC, \$1,500	1,400
6 mess attendants, SP-2, \$1,260 each	7,560
15 mess attendants, SP-1, \$1,020 each	15,300
	33,140

Occupational therapy (6) :

1 occupational therapy aide, SP-6, \$2,000	2,000
1 occupational therapy aide, SP-5, \$1,800	1,800
1 occupational therapy aide, SP-4, \$1,620	1,620
3 attendants, occupational therapy, SP-3, \$1,440 each	4,320
	9,740



## Physiotherapy (6) :

1 physiotherapy aide, SP-6, \$2,000	\$2,000
1 physiotherapy aide, SP-5, \$1,800	1,800
1 physiotherapy aide, SP-4, \$1,620	1,620
3 attendants, physiotherapy, SP-3, \$1,440 each	4,320

\$9,740

## Library and recreation (5) :

1 librarian, SP-6, \$2,000	2,000
1 librarian, SP-5, \$1,800	1,800
1 recreational aide, SP-6, \$2,000	2,000
1 recreational aide, SP-5, \$1,800	1,800
1 physical director, SP-6, \$2,000	2,000

9,600

## Social service (8) :

1 social worker, P&S-3, \$3,200	3,200
1 social worker, P&S-2, \$2,600	2,600
6 social workers, SP-7, \$2,300 each	13,800

19,600

## Construction

1,503,000

## Personnel

203,320

## Equipment

200,000

Total 1,903,320

Of this amount \$19,380 could be transferred from the Hines cancer unit, \$15,620 from the Mount Alto heart research unit and \$24,900 from the neuropsychiatric research unit at Northport, as the three existing research units could be merged with the larger organization were one established. A tentative personnel chart is outlined below:

Director, P&S-7	\$6,500
Assistant director, P&S-6	5,600
Chief pathologist, P&S-6	5,600
Chief, neuropsychiatric, P&S-6	5,600
Chief, general medical, P&S-6	5,600
Chief, tuberculosis, P&S-6	5,600
Chief, surgical, P&S-6	5,600
Neuropsychiatric specialist, P&S-5	4,600
Heart specialist, P&S-5	4,600
Cancer specialist, P&S-5	4,600
Physician (nutrition), P&S-5	4,600
Neuropsychiatric, P&S-4	3,800
Neuropsychiatric, P&S-4	3,800
Surgical, P&S-4	3,800
General medical, P&S-4	3,800
Pathologists, P&S-4 (2)	7,600
Neuropathologist, P&S-4	3,800
Physiological chemists, P&S-4 (2)	7,600
Physiological chemist, P&S-3	3,200
Statisticians, P&S-3 (2)	6,400
Statistician, P&S-2 (1)	2,600
Dietitian, P&S-2	2,600
Technicians:	
Laboratorians, expert, P&S-3 (3)	9,600
Laboratorians, SP-6 (8)	16,000
Laboratorians, SP-5 (8)	14,400
Photographer, SP-7	2,300
Social workers, SP-6 (2)	4,000
Laboratorian assistants, SP-2 (11)	14,520
Secretaries, CAF-5 (5)	10,000
Stenographers, CAF-3 (8)	12,960
Janitors, CPC-2 (4)	4,800
Laborers, CPC-2 (3)	3,600
Messengers, CPC-3 (2)	2,640
Total	202,320

A nutrition research unit should be operated as a part of the research institute. A dietitian, grade P&S-2, to assist in the work of the unit is included in the above list of personnel.

We feel reasonably sure that the forecast as to the future patient load, made by the Surgeon General, War Department, relative to the fiscal years 1943 and 1944 will be exceeded. We must suppose that the Army will before long be actively engaged, at least in the north African theater of operations, and severe casualties must normally be the expectation. Should an invasion of the European Continent be attempted, or hostilities develop widely in the South Pacific terrain, we should eventually have large casualty lists. Our organization, intimately in liaison with the armed forces at all times, should in time of war be in actuality a part of the armed forces. If the Army does become engaged in hostilities on a wide scale, it may reasonably be anticipated that their base hospitals will become congested, and that they will have a daily problem of bed supply. We should be the clearing point. We have facilities and personnel to treat any type of disease or injury; it is merely a matter of getting the disabled cleared into the nearest suitable facility of the Veterans' Administration.

The intangible factors which have been mentioned in my previous memorandum on this subject, make planning for the fiscal years 1943 and 1944 essentially tentative and subject to quick change. Such information as is available is too indefinite to plan our bed needs beyond the next 2 years. I understand a prospective schedule of 120,000 new beds to be secured by new construction, transfer of existing facilities of the Army and Navy to the Veterans' Administration or lease from private interests, is being studied. Whether or not even this comprehensive estimate will be sufficient is problematical. Statistical data on the basis of our experience after World War I should be helpful, but here again the numerous intangible factors of which I listed only eight in my memorandum of September 29, 1942, on this subject, vary considerably in most categories from those experienced in World War I, and requirements per 1,000 men numerical strength for the armed forces, as shown following World War I will consequently not be entirely applicable to our present problem.

Since vocational rehabilitation will be administered by the Veterans' Administration, there will, of course, be a need for personnel with a corresponding increase in space allotted. Following World War I, physicians were assigned to treat ex-servicemen at those points where training was given. If this policy is followed, additional physicians for out-patient service will be necessary.

Social workers, P&S-2, \$2,600, with training and experience preferably in the psychiatric or medical social work field and, if possible, with vocational counseling experience, will be required in hospitals and regional offices at the following three points; before, during, and at the end of the veteran's vocational training.

1. Before employment placement or vocational training is offered, to perform a screening and counseling service in connection with (a) immediate employment and (b) vocational training.

(a) With regard to immediate employment: To determine the veterans who are ready for employment directly, or who need counsel regarding job selection with the idea of entering employment directly after a suitable degree of physical and mental health is obtained; and to give the necessary guidance to such veterans, steering them to appropriate employment bureaus, etc.

(b) With regard to vocational training: To determine the veterans who need employment training, i. e., training on the job; or who need institutional, tutorial, or correspondence training; to make the preliminary study of the veteran's suitability for training by developing and verifying, when necessary, school, work, and health records; by learning what the veteran's interests are, what goals he has in mind, what prompts his interests in these directions, and how serious these interests are; and by determining, in collaboration with the physician, the bearing which the veteran's previous records, present medical reports, personal circumstances, and personality have on the possibility of achieving these particular goals. Such studies will provide a realistic basis for some prediction as to the veteran's suitability or lack of it for training of any kind, and his suitability for the particular training in which he has expressed interest, as well as give an opportunity for developing confidence in such training and the will to take advantage of his own potentialities.

If vocational training appears advisable, there should be discussions with him of the types of training for which he might be suited in the light of his education, past experience, and handicaps. There should be discussions of each veteran's case with the social work supervisor; the summary of the significant facts and the recommendations will be transmitted and interpreted to the training specialist, and made similarly available to the placement specialist. There should be participation in the case conferences which may be held by the physician, social worker, social work supervisor, psychologist, training specialist, and placement specialist in problem trainees while they are still hospitalized or under medical treatment and before they develop habits of invalidism, discouragement, dependency, or satisfaction with living on a pension permanently.

2. During training: To cooperate with the training specialist by observing the progress being made during training and by standing in the position of personal counselor or advisor to the trainee during the training period; to alleviate and correct situations in the way of attitudes that interfere with training or the personal and family circumstances that create anxiety that lessen ability to take full advantage of training opportunities.

3. After training: To render service at this transition point in making the personal readjustments required in going from the security of training to the uncertainties of employment. The object should be to prevent the appearance of such problems as loss of interest when employment is not immediately available, the wish to continue training indefinitely, the sense of inadequacy, a lack of desire to face the responsibilities in a paying job, or the reluctance to try to manage independently on the wages involved.

One such worker, P&S-2, \$2,000, should be provided for each 35 active potential trainees being studied or trained each month. Such social workers will be assistants to the chief social worker. At stations where such activities are carried on, the chief social worker should be in grade P-3, \$3,200. The chief social worker will, in addition to her other duties, keep informed and keep the social workers informed of the vocational opportunities and requirements in the various occupational fields confer with the social workers and review their reports to see that adequate preliminary study, employment and vocational counseling are being given the veterans, as well as effective social case work services during training and at the transition from training to employment.

Psychologists will be required to give intelligence, achievement, personality, aptitude and interest tests as a part of the original study of the veteran's suitability for employment or training and the suitability of his employment of training objective. Their reports will also assist the employment specialist in classifying the veteran at the appropriate level.

On the central office level, there will be needed an assistant to the chief of the Social Work section to be responsible for coordinating these basic social work steering and counseling features of vocational training, during the original study training and transition periods, with the other features of the training program; develop a staff of social workers with this specialized knowledge of vocational study and counseling which they will require; and direct the field staff that will be needed on a regional basis to supervise this program.

As a nation at war, our tuberculosis problem will assume increasing importance. Rehabilitation can be a most important adjunct in handling it. Expansion of this inadequately developed portion of antituberculosis work is feasible, practicable and sound. About half of the discharged tuberculous patients will need rehabilitation.

Study should be given to how far the Veterans' Administration is justified in rehabilitating tuberculosis beneficiaries for their outside existence by prolonging their stay in a comparatively costly environment of patients able to discontinue their routine and what assurance there is that if rehabilitated they will be able to stand up to earning their living?

If the tuberculosis hospitals can make them productive again, they will salvage as well as quarantine. These patients are in our hospitals for months to years while receiving treatment. Even while bed patients there is much of their time which can be occupied profitably and if for nothing but its psychological effect, patients need some pastime occupation while curing. It was for this purpose that occupational therapy was introduced into our hospitals. The ordinary lines of occupational therapy are sufficient for patients who are in for limited periods of time or who always will be patients. But for the greatly increased group of improved patients, arts and crafts and allied lines are not



sufficient. They need their spare time occupied on things more profitable. Rehabilitation training of the patient can be started as soon as any other line of occupational therapy. When an estimate of the disease processes are arrived at and the course of treatment decided upon, a beginning can be made in education. An early analysis of their social, educational and occupational background, of their interests and aptitudes, can be made and a course of training outlined. This can be made to synchronize with their medical treatment and other activities permitted and it can be carried throughout the full length of stay of the patients in the hospital. There are many of the facilities of the hospital which can be used for both training and physical rehabilitation. The program would require the coordination of the various staffs of the hospital and the occupational therapists provided we are willing to accept adult education as being a branch of occupational therapy.

A rehabilitation program which seeks to achieve four basic objectives could be inaugurated at our tuberculosis hospitals with some slight increase in personnel. These objectives are as follows:

1. To provide orientation to the patient new in tuberculosis and to aid in maintaining the adjustment of patients.

2. To give occupational redirection and guidance in terms of altered work tolerance, or capacity of patient.

3. To provide academic educational, and as far as possible prevocational, training with the medically controlled physical hardening this implies.

4. To provide efficient liaison with post sanatorium and follow-up agencies.

It is believed an adequate occupational therapy department and a social service department in each of our tuberculosis hospitals can develop a sound rehabilitation service with small additional expenditure.

Though one of our most important problems, finally, it is desired to direct your attention to the magnitude of the task confronting the Veterans' Administration with regard to the treatment of the neuroses. These neuroses consist, depending upon the specific precipitating factors and the duration of the condition, essentially of emotional instability, anxiety states, depressions, hysterical and hypochondriac conditions, or psychotic episodes.

In the last World War many of these conditions were expressed in psychosomatic disorders and this tendency will probably be exaggerated in the present war. Such symptoms may appear as fatigue, bodily pains, exhaustion, indigestion, gastrointestinal and respiratory disorders, asthma, cardiovascular disturbances or effort syndromes. All these disorders may be acute, subacute, or chronic. Experience has shown that such symptoms treated at the onset may be relieved more effectively than if they are permitted to crystallize. The type of psychiatric treatment to be given war neuroses depends on the etiological factors.

This problem is particularly serious because of our lack of preparation. We find ourselves unprepared because a realistic program for the satisfactory treatment of the neuroses was never developed following World War I, so at the present time we are confronted with the problems inherited from the past situation, to which will be pyramided the increments of neuroses from World War II and for which we have no organization to handle them.

Neuroses are being discharged from the Army by the thousands. It is true that less than 5 percent of those being discharged are considered incurred in line of duty, but certainly our experience following World War I, after the presumptive clause was adopted, indicates our potential load may be far greater than present statistics indicate.

Several things stand out as essential when considering the treatment of the psychoneurotic:

1. He should not be compensated for his illness.
2. He should not be treated in a hospital.
3. He should not be treated by a general practitioner.
4. Treatment should be brief but intensive.

The above four points when considered in relation to existing circumstances demonstrate the tremendous problem with which we are faced. It is generally recognized by all psychiatrists, and many of the laity, including the legal profession, that if treatment is to be effective, the psychoneurotic must not be compensated. Compensation with its many changing and intricate problems provides an endless cycle which prevents effective therapy. Hospitalization for other than a very brief period tends to break down morale and to create a feeling of dependency on the part of a neurotic. Treatment by other than a psychiatrist,

quite frequently results in a fixation of the neurosis and an active participation by the physician in the vicious cycle above referred to.

Considering the geographical location of the discharged ex-service men and women and the location of our facilities, it is apparent that we have no means of providing trained psychiatric treatment generally over the country. An adequate program would require the expenditure of millions of dollars. The development of mental hygiene clinics, with sufficient personnel, rather generally distributed over the United States and particularly in all urban areas, is essential. In many instances the non-service-connected ex-service individual, who is a potential beneficiary, would not receive early treatment which is so necessary in the psychoneurotic. The development and establishment of clinics would represent a great waste of money and personnel unless the present system of compensating the neuroses is eliminated. It is apparent, of course, that if compensation were eliminated the above program would pay for itself. It is believed that over \$1,300,000 is being spent monthly for the compensation of the neuroses from World War I. If a similar sum could be spent monthly for a limited time following World War II, for the purpose of assisting the patients to recover rather than compensating them for remaining ill, any program might be considered an economical one, irrespective of the immediate cost.

CHARLES M. GRIFFITH.

Chairman RANKIN. Of what do tropical diseases consist?

Dr. GRIFFITH. Elephantiasis, yellow fever, malaria, and all the parasitic diseases.

Chairman RANKIN. You would classify yellow fever and malaria as tropical diseases?

Dr. GRIFFITH. Yes, sir. We have 75 to 100 doctors from the South and the Gulf States who know malaria as good or better than any one else because they grew up with it. We had it as children and they know how to treat it.

Mrs. ROGERS. What about the fungus growths and kidney diseases? Have you specialists on those lines?

Dr. GRIFFITH. Yes, ma'am; and allergy clinics; our best one is at the University of Pittsburgh, Pa.

Chairman RANKIN. Both yellow fever and malaria are transmitted by mosquitos?

Dr. GRIFFITH. Yes, sir.

Mrs. ROGERS. Doctor, do you have a copy of the letter that was sent by the Secretary of War to General Hines regarding the rescinding of the order relating to the transfer of Army doctors to the Veterans' Administration?

Dr. GRIFFITH. I know of the correspondence. We requested the War Department not to send any more doctors to us who did not want to come to us, and those doctors who were disgruntled, dissatisfied, that were with us to go back. I do not know of any correspondence that stopped or just closed down.

Mrs. ROGERS. The War Department told me they would not transfer any men from the Army to the Veterans' Administration at the present time, and that they were going to retire all men over 64, Veteran or Army men.

Dr. GRIFFITH. Directive 181 states that they are retiring in the next few months all men who have reached the age of 64. Now the Surgeon General's Office—I was talking to the Surgeon General about it, and we have quite a number of men who will reach 64 in a few months.

Mrs. ROGERS. That further complicates your problem.

Dr. GRIFFITH. And a communication has gone to the War Department to be sent up to the Surgeon General's Office to give consideration to not retiring those men on duty with us who want to stay.

Mr. SCRIVNER. While we are on the Army officer situation, may I interrupt at this point?

Mrs. ROGERS. I yield.

Mr. SCRIVNER. Doctor, how many men do you have assigned from the Army?

Dr. GRIFFITH. Congressman, out of 2,562 men on duty, VA physicians, commissioned and retired, in the hospital service 1,102 are from the Army and 2 from the Navy, or a total of 1,104. Former VA employees returned to duty in the medical and hospital service by the armed forces were 98.

Commissioned officers on detail in the medical and hospital service were 554 from the Army and 16 from the Navy, or a total of 570.

The total commissioned officers on duty in the medical and hospital service are 1,754 from the Army and 18 from the Navy, or 1,772 altogether. The total civilian medical officers in the medical and hospital service are 423, so that there is a total Army and Navy and civilian physicians in the hospital service of 2,195.

Mr. SCRIVNER. In other words, you have about 500 assigned from the Army. Is that right?

Dr. GRIFFITH. Yes, sir.

Mr. SCRIVNER. How many of them do you have like this man, this doctor about whom I am talking now, on whom the reports were adverse? He was transferred to Wadsworth. At my request a report was made concerning this major, and this was his attitude, and if this is typical of the attitude of the men you have had, it would probably be a good thing if you got rid of all like him.

He is very dissatisfied with his assignment and does not only cuss this institution but "god damns" the Army as well as everything pertaining to a veterans' facility. He does not have any use for a veteran finding it necessary to enter a veterans' hospital, and says they are all "nuts" for being here, and he has stated that they just enter a "damn" place like this to get out of work and to cause people to "have to pay higher taxes." He has stated that he did not intend to do any good work or does not intend to do anything that he did not actually have to do, and that he was not going to be subject to the "illicit practice of medicine" such as was required by the Veterans' Administration and that the quicker he could get out of the "god-damn Army" and away from the Veterans' Administration, the better satisfied he would be.

Chairman RANKIN. What is his name?

Mr. SCRIVNER. The name of the officer is Berger.

Chairman RANKIN. How do you spell it?

Mr. SCRIVNER. B-e-r-g-e-r.

Chairman RANKIN. Where is this man from?

Mr. SCRIVNER. I have no idea.

Mr. ALLEN. Is he in the service now?

Mr. SCRIVNER. At Wadsworth, Kans.

Mr. ALLEN. He is no native of Kansas.

Mr. SCRIVNER. I know nothing about the man whatsoever.



Chairman RANKIN. I will ask the Doctor to look that man up and tell us who he is. He is in a class by himself, because I never heard of a doctor taking that attitude.

Mr. SCRIVNER. Here is the situation, Mr. Chairman, that if there is one doctor like that serving our veterans, it is one too many.

Dr. GRIFFITH. That is right, sir.

Mr. SCRIVNER. And an attitude expressed by a man like that who is vicious enough, why of course the attitude of that one man might spread to other men until finally where you have had a pretty good hospital, as, for example, at Wadsworth, Kans., it would deteriorate.

Chairman RANKIN. When did he make that statement?

Mr. SCRIVNER. During the past few weeks. I just got the report yesterday and I intended to forward it.

Mr. DOMENGEAUX. I would say in regard to those cases in North Carolina, I had three doctors whose names I have in my file who made statements not quite as strong as that, but certainly indicative of complete dissatisfaction.

Mr. SCRIVNER. If I may go one step further, another thing which is quite disturbing is this reaction on the statement on "illicit practice of medicine" in the Veterans' Hospital. Now I do not know what he meant by that, and it may be that somebody can find out what he is referring to; for comments like that to me are not excusable.

Dr. GRIFFITH. That is right.

Chairman RANKIN. Did he write that statement out?

Mr. SCRIVNER. This report was made to me and this is a report of a statement that he had made repeatedly.

Chairman RANKIN. He did not make this statement to you, did he?

Mr. SCRIVNER. The man who gave me the report, I have known him for 25 years and he never lied to me yet. If he said that is what the man said, you can depend on it, that is what he said.

Mrs. ROGERS. Isn't it true that General Kirk did not want to transfer the doctors of the Veterans' Administration, and he asked that the Veterans' Administration set up its own course?

Dr. GRIFFITH. I think the Surgeon General feels that we should have our own course.

Mrs. ROGERS. That is why I wanted to help by having the Surgeon General of the Army and the Surgeon General of the Navy come before this committee. You recall that General Hines was called before the Military Affairs Committee. There is a very close relationship between the three services. It is just as important to give a man just as much care in a Veterans' Administration hospital as he gets in the Army or the Navy. I think Generals Kirk and McIntyre would do all they can for them.

Dr. GRIFFITH. I feel we should have our own organization. Out at Wadsworth and down at Oteen, N. C., and in one or two of the Western States we had about five or six Bolsheviks. The Army did not want them and handed them over to us. Three of that crowd were at Wadsworth that we wanted to dispose of.

Mr. SCRIVER. And this would make a fitting fourth.

Dr. GRIFFITH. I think this one is, but I will not make a definite statement until I check.

Mrs. ROGERS. Dr. Griffith, are there many doctors in the VA who feel that way?

Dr. GRIFFITH. We have a small percentage of doctors that if I were running my own private show I would not have.

(The following was submitted for the record:)

*Medical officers on duty in the Veterans' Administration, June 14, 1945*

	Army	Navy	Civilians	Total
<b>MEDICAL AND HOSPITAL SERVICE</b>				
Veterans' Administration physicians commissioned and retained in the medical and hospital service.....	1,102	2		1,104
Former Veterans' Administration employees returned to duty in the medical and hospital service by the armed forces.....	98			98
Commissioned officers on detail in the medical and hospital service.....	554	16		570
Total commissioned officers on duty in the medical and hospital service.....	1,754	18		1,772
Total civilian medical officers in the medical and hospital service.....			423	423
Total physicians in medical and hospital service.....	1,754	18	423	2,195
<b>ADJUDICATION SERVICE</b>				
Veterans' Administration physicians commissioned and retained in the adjudication service.....	46	3		49
Commissioned officers on detail in the adjudication service.....	83	39		122
Total commissioned officers on duty in the adjudication service.....	129	42		171
Total civilian medical officers in the adjudication service.....			196	196
Total physicians in adjudication service.....	129	42	196	367
Grand total.....	1,883	60	619	2,562
Total commissioned officers (Army and Navy) in the Veterans' Administration.....				1,943
Total civilians in Veterans' Administration.....				619
Total.....				2,562

Mrs. ROGERS. You have had a difficult time securing nurses due to the war shortage.

Dr. GRIFFITH. That is right, and we are still approximately 1,000 nurses short now. We will have 2,700 beds come in in the next 90 days and I do not know where the nurse personnel will come from.

Mrs. ROGERS. And how many beds will you be unable to open because of the lack of nurses?

Dr. GRIFFITH. Seven hundred, one section in one hospital, and so on down the line.

Mrs. ROGERS. In answer to a campaign for nurses, how many applications or letters did you have inquiring about your service?

Dr. GRIFFITH. We have a nurse unit, a publicity agent, and we have sent out to all nursing organization, State departments, all training schools, approximately 100,000 communications. We have sent our nurses out to training centers where nurses were available. We have sent assistant nurses out, training cadet nurses, 12 or 15 at a time. We have a considerable number in that group. We have authority for 5,450 authorized nurses' jobs, and that will go up, of course, as additional beds come in. At the present time we have 997 vacancies.

Mrs. ROGERS. If Miss Andrews was here, she could give us information on our inquiries and give us data on the number of recruits.

Dr. GRIFFITH. She can give you that figure and I can give you most of that now.

Mrs. ROGERS. Can she give it now?

Dr. GRIFFITH. I do not know if she came over with the figures. We will furnish them later on.

Mr. SCRIVNER. Doctor, I notice in these figures that I put in the record yesterday that since the 13th of June in 1944, in order to maintain a force of 3,991 you hired 1,701 new nurses. In other words you had a turn-over of 43 percent.

Dr. GRIFFITH. That is right.

Mr. SCRIVNER. The year previous to that, from June 30, 1943, to June 30, 1944, you had a turn-over of 33 percent. In other words, to keep your force up to 3,856, you had to hire 1,349.

Dr. GRIFFITH. That is not far wrong.

Mr. SCRIVNER. And, of course, when you get over in the attendant group—

Dr. GRIFFITH. Yes, it is worse there.

Mr. SCRIVNER. From June 30, 1933, to June 30, 1944, to maintain a staff of 15,024 positions you had to hire 11,047 replacements.

Dr. GRIFFITH. Yes, sir; it is getting worse.

Mr. SCRIVNER. That is about an 80 percent turn-over.

Dr. GRIFFITH. And it is getting worse.

Mr. SCRIVNER. These figures would indicate that starting with June 30, 1940, to June 30, 1941, your attendant turn-over was 50 percent, and it has gone up now to 80 percent.

With the chairman's permission, I would like to get back to the situation of this Army doctor.

Chairman RANKIN. He did not seem to think highly of the Army.

Dr. GRIFFITH. That is right.

Chairman RANKIN. Can you give us the man who made this statement?

Mr. SCRIVNER. I can, but I will give it to you off the record.

Chairman RANKIN. All right.

Mr. SCRIVNER. If that were the only case, I would not feel quite so badly about it; but when I made my report on the Wichita situation, one of the men assigned, a major on the rating board, his attitude as expressed to me personally was that 90 percent of the men coming in were coming in for a meal and a bed. Now what kind of a deal would a man get, coming before a board of which one member had that attitude?

Dr. GRIFFITH. He would not get anywhere.

Chairman RANKIN. One of the Army men transferred there?

Mr. SCRIVNER. Yes.

Chairman RANKIN. What is his name?

Mr. SCRIVNER. I reported on that when I reported on the Wichita Hospital.

Mrs. ROGERS. That shows the importance of the Veterans' Administration having its own medical corps.

Dr. GRIFFITH. That is one of the 57 reasons.

Chairman RANKIN. That is what we contended all the time. The Army turned over to the Veterans' Administration the doctors it does not want itself.

Dr. GRIFFITH. That is not true in many cases.



Mr. SCRIVNER. Certainly it is true in many cases. I have had military training myself and we did not get rid of our first-class soldiers, but we got rid of those we wanted to get rid of that made trouble in our own unit.

Mr. BENNETT. Dr. Griffith, these half a dozen that you have referred to, were they sent to you by the Army?

Dr. GRIFFITH. I think the majority of them were sent to us by the Army. However, I want to clarify that statement, gentlemen. The Army told us: "Here are limited-service men, both professional and enlisted men. They are not fit for combat service and we cannot use them. Do you want them?" They did not misrepresent them to us. We were desperate and we took them.

Mr. SCRIVNER. I think you were faced with a situation where you had to look for some remedy.

Dr. GRIFFITH. Yes, and we had to take the chance.

Mr. SCRIVNER. But I think, Mr. Chairman, in many cases, despite these one, two, three, or half a dozen, I think in all fairness it should be said that many of these men who were assigned by the Army, maybe they did not like their assignment but being soldiers as they are, I think many of them have tried to make the best of the situation even though unhappy; and I think many of them, in all fairness, have performed their duties faithfully.

Dr. GRIFFITH. I am glad you said that.

Mr. SCRIVNER. But it is like any organization, whether the church or the American Legion, you may have a few individuals that everybody picks at and criticizes and the entire organization gets the blame for those few who do not measure up to the standard.

Dr. GRIFFITH. That is correct.

Chairman RANKIN. Don't you think it was probably a few of that type who talked to Mr. ——— whom we had before the committee and he refused to divulge the names of the persons who made the complaints when we asked him the direct question?

Mr. SCRIVNER. I have no way of knowing, but the few who have made the statements have caused a lot of adverse criticism.

Chairman RANKIN. Of course, every court in the land has held that the questions we asked that man to answer were not in regard to privileged communications. In other words, he did not have a right to withhold his answers. Apparently those were the type of men he talked to, and when I tried to make him tell, why the committee overruled me. Now, here we are.

Mr. SCRIVNER. I do not think they are all in that class.

Chairman RANKIN. If you had let me alone, I would have compelled him to answer the questions or have gone to jail in case he refused. I think you would have obtained the names of some of those fellows who are in the class with the men Mr. Scrivner just described.

Mrs. ROGERS. Have you any doctors in the Veterans' Administration who are giving too many drugs and narcotics?

Dr. GRIFFITH. No.

Mrs. ROGERS. Have you any at the Mount Alto Sanitarium? That is, a doctor who gave too many narcotics to patients.

Dr. GRIFFITH. Yes; we had a little problem there and it has been corrected and that particular doctor was discharged and he was returned to civilian life.

Mrs. ROGERS. He is out of the civil service?

Dr. GRIFFITH. He was an unfortunate victim himself.

Mr. DOMENGEAUX. If you want the names of the doctors, I will be glad to give them.

Mr. SCRIVNER. You have not had an opportunity to make your report.

Dr. GRIFFITH. I would like to make this comment to that gentleman [indicating Mr. Domengeaux]. I know the men he interviewed and we have been trying our best to get rid of some of them.

Mr. DOMENGEAUX. I did not pick them out.

Dr. GRIFFITH. I know you did not. I want to make one more statement.

Mr. DOMENGEAUX. I will say this, that they were Army doctors. I will give you this: There was one of them, Major Beverly, who has been there 8 years in that hospital and with the Veterans' Administration for many, many years.

Dr. GRIFFITH. He is one of our own men. For your own information, Congressman, he was perfectly happy until we changed managers and clinical director and Dr. Beverly did not get the job he wanted.

Mr. DOMENGEAUX. Beverly was certainly not complimentary of what was going on there.

Dr. GRIFFITH. He was not?

Mr. DOMENGEAUX. That Oteen needed an overhauling.

Dr. GRIFFITH. I would appreciate in a few weeks if you would go back and visit that hospital.

Mr. DOMENGEAUX. Anything done would improve it.

Dr. GRIFFITH. May I go on?

Chairman RANKIN. Oteen is a tubercular hospital. We have been criticized for not doing more research than we are. We have had individuals from other countries come to see what our clinics and our work were. We have a cardio vascular research unit going at Mount Alto and that unit has done exceptionally fine work. There are six of such units in the medical service but we have had to curtail that work. We have an NP research unit going and we have other projects going.

We said we did not encourage doctors in research. We encourage any doctor who can do research, but we are not going to encourage somebody just to play with it.

You are not interested in someone who wants to experiment.

Dr. GRIFFITH. We will not tolerate that, Mr. Chairman.

Chairman RANKIN. Doctor, I asked you what you classify as tropical diseases. Yellow fever and malaria and what else?

Dr. GRIFFITH. Elephantiasis and the various parasitic diseases.

Chairman RANKIN. All right. Do you call hookworm a tropical disease?

Dr. GRIFFITH. Yes, sir.

Chairman RANKIN. Do you have any research going on in that field?

Dr. GRIFFITH. We have had considerable study on the hookworm. Mr. Congressman, and the Public Health Service has got all the information we need.

Chairman RANKIN. Of course, yellow fever is usually confined to the Tropics.

Dr. GRIFFITH. No, sir; at one time we had an epidemic of yellow fever in the United States. You might say it is classified as a tropical

disease, but you can pick the bug up any place. You might pick it up in Chicago or Minneapolis.

Chairman RANKIN. All right.

Malaria is the same thing as yellow fever, isn't it?

Dr. GRIFFITH. That is right.

Chairman RANKIN. It is transmitted by the mosquito?

Dr. GRIFFITH. Yes, sir.

Chairman RANKIN. You have learned how to combat those diseases and you have learned also how to combat the hookworm.

Dr. GRIFFITH. And a number of the others.

Chairman RANKIN. There are other diseases, such as those relating to the thyroid gland and special food research.

Dr. GRIFFITH. We have had considerable study on that.

Chairman RANKIN. Have you issued any bulletins?

Dr. GRIFFITH. There is still a lot to be learned on thyroid.

Mr. AUCHINCLOSS. Doctor, I think you said the Administration encourages doctors to engage in research.

Dr. GRIFFITH. Yes, sir; if they can do it.

Mr. AUCHINCLOSS. Will you be more specific? In what way do you encourage them?

Dr. GRIFFITH. Any doctor who has a background and has studied in any particular specialty of disease, we encourage him and push him along in it; but if he wants to take something up and play with it through curiosity, we do not fool with him.

Mr. AUCHINCLOSS. What, specifically, do you do to encourage research?

Dr. GRIFFITH. One of our requirements: We let up on it a little since the war, we make every doctor in the service take a subject and write a paper on it and send it in to C. O. It is reviewed. If it is worth publication, we publish it. In that way and in many other ways the clinical doctor finds if this doctor is interested in some specialty.

Mr. AUCHINCLOSS. You are finding out what doctors are interested. What do you do to encourage research?

Dr. GRIFFITH. If they will do it and show an interest.

Mr. AUCHINCLOSS. Do you offer them any facilities?

Dr. GRIFFITH. We have got 37 post-graduate courses going right now.

Mr. AUCHINCLOSS. Do you offer them any reward for any research they might do?

Dr. GRIFFITH. We do not offer any rewards.

Mr. AUCHINCLOSS. There is no particular incentive to carry on any research.

Dr. GRIFFITH. A good doctor will do it for his own knowledge and benefit rather than a reward.

Mr. AUCHINCLOSS. That is your opinion?

Dr. GRIFFITH. Yes, sir.

Mr. AUCHINCLOSS. I would like to know what you are doing.

Dr. GRIFFITH. We encourage him, if he will do it, but we are not giving a reward.

Mr. AUCHINCLOSS. I think your answer is that you are doing mighty little to encourage research; you haven't told me anything yet. You do not want to comment on my remarks?

Dr. GRIFFITH. I have told you all I can tell you, Congressman.



There is an extensive study being made in X-rays now. The Administrator has appointed a rather high-powered board of five outstanding X-ray men in the country. They have been studying the various types of X-rays: 17 by 14, 35 millimeter, 8 by 10, and paper film—for the purpose of determining and, if possible, finding out the best X-ray procedures to be followed; and now in the discharge of all of these 15,000,000 people coming out of the service, that board has been in session and has been studying for several months.

We went to the Bronx. We took all the folders of employees and patients that would have X-rays made, of all of the different types. We went to Dayton and we got some 5,000 in all. That comparative study is being made now and will be completed within a few weeks.

Chairman RANKIN. Doctor, do you think the passage of this bill for the establishment of the Medical Corps will help to relieve the situation?

Dr. GRIFFITH. Mr. Chairman, I would like to comment a moment in regard to that.

Mr. McQUEEN. Dr. Griffith, you are introducing this X-ray analysis in the record?

Dr. GRIFFITH. Yes, sir.

Chairman RANKIN. Let me see it [examining exhibit].

Without objection it will be inserted in the record at this point.

(The comparative X-ray board statement is as follows:)

#### COMPARATIVE X-RAY BOARD

##### PURPOSE OF COMPARATIVE STUDY

Having in mind the large number of veterans who will come under the observation of the Army, Navy, and United States Public Health Service upon demobilization and the equally great potential number of these veterans who, after discharge, become the beneficiaries of the Veterans' Administration, the Administrator recognized the importance of satisfactory records of physical conditions, particularly X-ray chest examinations. It was for the purpose of making a comprehensive comparative study of the various methods in general use for rapid survey of the chest for tuberculosis and other potential disablements that this Board was established.

##### ESTABLISHMENT

The desirability for such a study was taken up with the Surgeon General, United States Public Health Service, who readily offered what assistance his agency could give in the solution of the problem. The approval for the setting up of such a Board was given by the Administrator, Veterans' Administration, on December 4, 1943.

##### MEMBERS OF THE BOARD

Outstanding roentgenologists who had more than the average experience in at least three of the four types of films were invited to help in the finding of a solution of the problem. Those appointed are—

Name	Address
Dr. Carl C. Birkelo-----	Herman Kiefer Hospital, Taylor and Hamilton Aves., Detroit 2, Mich.
Dr. W. Edward Chamberlain----	Board in Radiology, Temple University, 3401 North Broad St., Philadelphia 40, Pa.
Dr. Paul S. Phelps-----	Department of TB Control, State Office Bldg., Hartford 6, Conn.
Dr. Percy E. Schools-----	3612 Noble Ave., Richmond, Va.
Dr. David Zacks-----	The Commonwealth of Massachusetts, Department of Public Health, State House, Boston, Mass.

Dr. Chamberlain consented to act as chairman. Dr. J. Yerushalmy, principal medical statistician, National Institute of Health, Bethesda, Md., has also rendered invaluable assistance.

#### HOW APPOINTED

The members of this Board are appointed on a part-time basis of \$1,200 per annum; and they are now serving their second year.

#### NUMBER OF CONFERENCES HELD

Three—April 1944, January and April 1945.

#### PROCEDURE EMPLOYED IN READING THE FILMS

To facilitate the study, it was divided into two parts. The first part consists of approximately 1,200 subjects X-rayed at the Veterans' Administration Facility, Bronx, New York; and the second consists of 3,500 individuals X-rayed at the Veterans' Administration, Dayton, Ohio. One part is called the Bronx Series and the other the Dayton Series; and each series is being read by all five of the consultant readers by the four methods, which are—

14 by 17 single chest radiographs on transparent base films.

14 by 17 single chest radiographs on paper base films.

4 by 5 stereoscopic miniature photofluorographs on 4 by 10 films.

35 millimeter single microphotofluorographic films.

The hospitals selected at Bronx and Dayton were chosen because they are concerned with the care and treatment of general cases and, therefore, would be representative of the type of cases which would be usually encountered. X-rays were taken of both patients and personnel at these points.

The volume of work in the aggregate will probably total 12,000 films. In conducting the study of the Bronx Series, a complete set of films for a specific method; that is, the 14 by 17 paper, the 4 by 10 stereo, the 35 millimeter photofluorographic, and the 14 by 17 celluloid, was sent to each individual reader and then returned to Washington for shipment to another consultant. Due to transportation difficulties, and especially to the inability of the five very busy consultant roentgenologists to interpret a considerable number of our comparison films at any one time, because of the press of their private consultations, there was considerable delay in the Bronx Series.

In order to expedite the Dayton Series, it was determined desirable to break each complete set of films into 5 parts of 300 films each. Each small lot of the method under study is shipped to one of the consultant readers, who, in turn, on completion of his interpretation of this small lot, ships them to the next designated consultant reader. In this way the time required for the study of the films of each method will be shortened and the study will be expedited materially. The readers have assured me that they are interpreting the films as rapidly as possible consistent with their other responsibilities. However, in spite of this new procedure, it is anticipated that it will be October 1, 1945, before a preliminary report can be made. A final analysis will then be made of the study.

#### COST

Salaries and travel and per diem allowances as of June 1, 1945, is approximately \$9,220; equipment as of the same date approximately \$10,000.

Dr. GRIFFITH. And I would also like to insert in the record at this point my research program.

Chairman RANKIN. Without objection it may be inserted in the record at this point.

(The research program is as follows:)

#### MEDICAL RESEARCH

In the fall of 1930, specifically November 15, a conference was held between three members of the Medical Council, namely, Drs. Lewellys F. Barker, George M. Klein, and Roy D. Adams in collaboration with interested officials in the Veterans' Administration for the purpose of discussing the establishment of medical research work in the Administration. It was the consensus of opinion of the group

that medical research should be initiated by the Administration itself and conducted in its institutions.

The Administrator was advised under date of December 8, 1930, that the cost of the plan would be somewhere between \$30,000 and \$50,000 annually for salaries, most of the equipment being available. In reply to this memorandum the Administrator raised the question as to the justification of organized research of the character recommended and he requested further information in regard to salaries, etc.

The Medical Director was then requested to make a statement as to the actual need for research in the Administration which cannot be met by other agencies outside of the Veterans' Administration. On January 6, 1931, the Administrator was advised that positions should be set up in grade P&S-7 in order to attract high-grade clinicians, as the purpose of the establishment of research work was to extend and improve the medical work now being carried on in this Administration.

Following the submission of this memorandum the Administrator advised that the matter should be deferred until July 1, 1931, and the number of appointments should be limited to five physicians.

The Assistant Administrator under date of July 15, 1931, requested budget allocation of \$30,000 and stated that it was proposed to limit the initial project to research in neuropsychiatric disabilities. This memorandum was forwarded, unsigned, to the Budget officer who in reply stated that no sum was to be allotted without the Administrator's specific approval and raised the question for the need of \$30,000 when the personnel listed as necessary to establish the neuropsychiatric research unit covered a total of \$17,960 only.

The Administrator was informed on July 30, 1931, that the sum requested was considered most moderate and that the term "specialist in research" should be used as a designation for the medical officer in charge of the proposed unit.

The executive assistant to the Administrator returned the file under date of August 1, 1941, stating that he did not think the proposal could be finally acted upon by the Administrator unless he was definitely advised as to the amount involved annually, say, for the next 5 years. He also stated that no purpose could be served in starting such a study for a period of several months and then having to discontinue it due to lack of funds, or in not permitting its development along other lines because our appropriations from year to year have not taken into account any increased expense which might be incident to such development.

The executive assistant was then advised that it was proposed limiting the budget for medical research for 1932 to approximately \$30,000 and for 1933-35, inclusive, the annual budget allowance of \$50,000 would suffice to take care of the plan of the medical and hospital service in the conduct of clinical research.

Under date of August 26, 1931, the Administrator approved the establishment of medical research, generally in line with recommendations; however, with the stipulation that the expenses for the current fiscal year, 1932, should not exceed \$30,000 and that a like amount would be set up for the fiscal year 1933.

The Administrator suggested that the proposed Neuropsychiatric Research Unit should be established at the Palo Alto Facility. However, the suggestion was made to him on September 8, 1931, that the unit be established at the Bedford Hospital which is located near a large medical center, Boston, Mass., as well as near Harvard Medical School. The Administrator was also advised that the allotment of \$30,000 for 2 years would limit research activities materially and only a skeleton force of personnel and equipment could be made available.

Under date of November 7, 1931, the Assistant Administrator recommended the assignment of one of the clinical directors as head of the research in neuropsychiatry in grade P&S-6 to be effective December 1, 1931. It was determined that a maximum of \$14,000 would be available for salaries and expenses, which limited the scope of the proposed work materially. The Chief reported January 1, 1932, and every effort was made to arrange for the establishment of a unit to serve as a nucleus for research work in neuropsychiatry. Requisitions were submitted for necessary laboratory equipment and personnel.

However, on February 17, 1932, three of the members of the medical council advised the Medical Director that it was their understanding approximately \$50,000 would be made available for this purpose. They held a conference with the manager, Veterans' Administration, Bedford, Mass., and the chief of the unit in regard to necessary facilities, both as regards physical set-up as well as personnel for a minimum program, without which it would be futile to embark on a



research program. Existing quarters were quite inadequate and unless certain alterations were made immediately, work would be seriously delayed. It was essential that at least the sum of \$30,000 be made available.

Due to inability to secure technical personnel through civil service and refusal to grant authority to make local appointments, and to the inadequate space for establishment of the unit a recommendation was made to the Administrator April 6, 1932, to the effect that the thought of instigating research work at Bedford be postponed for the time being and all research activities be devoted to cancer study until such time as adequate facilities and funds could be made available.

Following this a cancer research unit was established at the Hines Facility in the spring of 1933 under the direction of Dr. Max Cutler.

Under date of April 17, 1933, the chairman of the group on research of the medical council indicated to the Administrator that it was understood that contemplated administrative economies would affect adversely the research work undertaken under the stimulation of the research committee of the medical council. A statement was made to the effect that the chairman understood the saving in moneys would be effected by the elimination of the research work in central office and that the allotment for the cancer research unit established at Hines, Ill., would be only \$17,000 a year.

The chairman of the medical council also contacted the Administrator and stated that he hoped that drastic necessary economies would not interfere with the research work already started.

In the submission of Dr. Barker's letter to the Medical Director for the preparation of a reply the Assistant Administrator indicated that he believed we should continue research work along the lines developed last year.

A letter was directed to Dr. Barker, chairman of the medical council, by the Administrator, April 26, 1933, in which it was stated:

"So far as the exigencies of the present economy program of the Government will permit, I shall be favorable to continuation of the research work in central office as well as the maintenance of the cancer research unit now established at Hines, Ill."

The executive assistant to the Administrator in presenting the letter to Dr. Barker for signature made this statement:

"Prepared reply is guarded and if appropriations do not permit obviously this work will have to be curtailed or discontinued. Feel it should be retained, if possible. Believe the letter may be safely signed."

A similar letter was directed to the chairman of the group on research of the medical council under date of April 21, 1933.

A cardiovascular research unit was established May 1, 1936, this unit being located at the Veterans' Administration facility, Washington, D. C.

A neuropsychiatric research unit was established in 1941 and is now in operation at the Veterans' Administration facility, Northport, Long Island, N. Y.

Mr. BENNETT. Have you had many X-ray burns?

Dr. GRIFFITH. We have had several X-ray burns and possibly one death. In any civilian or any other institution that does a lot of X-ray work, they are sometimes going to have people burned.

Chairman RANKIN. How many X-ray examinations have you made?

Dr. GRIFFITH. Do you mean for treatment purposes?

Chairman RANKIN. Yes.

Dr. GRIFFITH. Oh, I guess one million.

Chairman RANKIN. And you have only had one death out of that many?

Dr. GRIFFITH. That is all I recall.

Chairman RANKIN. And how many burns have you had?

Dr. GRIFFITH. I cannot give you the exact number right now, Mr. Chairman, but very few.

Chairman RANKIN. Does that happen in civilian hospitals too?

Dr. GRIFFITH. Yes, sir.

Mr. BENNETT. To what do you attribute the burns? To poor personnel or carelessness?

Dr. GRIFFITH. I would not attribute it to carelessness. The individual has got to estimate the amount of voltage and amperage and he must take a chance on how sensitive the skin is to the X-ray.

Mr. ERVIN. Is an injury of that character compensable?

Dr. GRIFFITH. Yes, sir; if we burn a man, if any treatment that we give results in injury to the patient, he is compensated for it.

Chairman RANKIN. Doctor, the fact that some people are more sensitive to sunburn would also apply to the X-ray?

Dr. GRIFFITH. There are a lot of people who can get a sunburn even to a second-degree burn.

Chairman RANKIN. That is right. If I were to get out and play baseball, and I am speaking from experience, if I were to play ball without sleeves, I would suffer for a week; yet I have seen other boys play all season without sleeves and it would not bother them at all.

Dr. GRIFFITH. Now there has been a lot said about compensating them for burns.

Mrs. ROGERS. How do you compensate them, Dr. Griffith?

Dr. GRIFFITH. For burns?

Mrs. ROGERS. Does the patient have to go to the court?

Dr. GRIFFITH. The whole record is submitted to one of the rating boards and they consider it.

Mrs. ROGERS. What is the rate of compensation? Can you give us an idea?

Dr. GRIFFITH. It varies.

Mrs. ROGERS. What would it be for a deep burn? What would it be for a death?

Mr. MATHES. That is not under our jurisdiction; it is under the rating schedule. There are some exceptions to my statement. Section 31, Public Law 141, is the authorization for it.

Mrs. ROGERS. I think that section should go in the record.

Mr. PICKETT. I think all members of the committee are familiar with the case I reported of John W. Davis, who received burns while he was undergoing treatment at the veterans' facility. You are familiar with that, I suppose.

Dr. GRIFFITH. Yes, sir; and it is now receiving rating consideration.

Chairman RANKIN. I might say we had this up when we had the gentleman present from that hospital and his letter.

Dr. GRIFFITH. We are giving preferred attention to that case at this time.

Mr. PICKETT. I wonder whether in a short time we could determine what will be done with it.

Dr. GRIFFITH. Mr. Pickett, the case is being briefed and the consultant went over some of it yesterday and the day before, and it was sent to them for complete study.

Now, there are approximately the following consultants, attending specialists, and general examiners on part time and fee basis in the facilities proper, including all specialties: General medical, 453 consultants; tuberculosis hospitals, 30; neuropsychiatric, 135. Now they are called as needed. Many of these men are busy. Now, before the war, we had about 900 part-time men scattered all over the country in various small towns and cities. Those men and doctors have gone from the respective towns and they have had to take on the practice of two or three other towns in that community and neighborhood, and

we are having difficulty in getting doctors on a fee basis and part time, just as much as we have trouble in getting a doctor on full time. A doctor can do just so much in 24 hours and we have several thousand special examinations that we are back on on that account.

Mrs. ROGERS. What is being done for the women in the way of hospitalization today?

Dr. GRIFFITH. Of course, this act is authority for the hospitalization of them in civilian hospitals, regardless of service connection. The director of construction is building buildings now and construction for women in all our hospitals, both NP, TB, and general NP, TB.

Mrs. ROGERS. How many institutions for women, not State institutions?

Dr. GRIFFITH. There are a considerable number, Mrs. Rogers; I cannot give the exact figures.

Mrs. ROGERS. I think you might have it for the record.

Dr. GRIFFITH. Do you want the number of women in State institutions?

Chairman RANKIN. The number of Waves and Wacs?

Dr. GRIFFITH. Waves, Wacs, nurses, Spars, and so forth.

Chairman RANKIN. You mean the number of women from the service—all the women?

Mrs. ROGERS. The number of the servicewomen.

Chairman RANKIN. You may add that to your statement, Doctor. (The statement is as follows:)

*Women beneficiaries*

Civil and State, including 1 in insular possessions-----	211
Veterans' Administration-----	463
Other Government-----	34

Total women hospitalized (this does not include domiciliary cases),  
July 16, 1945----- 708

Mrs. ROGERS. We want to know the number of women in private institutions.

Dr. GRIFFITH. We will get it.

Mrs. ROGERS. We are getting so many protests about it, that there is crowding in the State hospitals.

Dr. GRIFFITH. They are crowded now.

Chairman RANKIN. Do you know of a hospital which is not crowded now?

Dr. GRIFFITH. We have been criticized for crowding but we have got wide-open spaces, compared to what is the case in private institutions today. They are twice as crowded as we are.

Mrs. ROGERS. I think if General Hines had asked for priority, we would have seen that he got it so that he would not have had to wait for materials.

Mr. ODOM. Do you know how many hospital beds are now available?

Dr. GRIFFITH. We have 2,700 beds coming in; that is additional, in the next 60 days, and I do not have a nurse, a technician, or a doctor to man those beds today.

Chairman RANKIN. You will not be able to get those doctors unless you change the law.

Dr. GRIFFITH. I doubt it.



Mr. ODOM. Will you be able to get them after you change the law?

Dr. GRIFFITH. I will have to enter into the corps bill right now to answer your question.

Chairman RANKIN. All right.

Dr. GRIFFITH. I am in favor of the Bureau of Medicine and Surgery, call it a corps or whatever you want to call it. I am in favor and advocating, and want to be able for the Administrator and the Medical Director to be able to select and set up the necessary machinery to select all of our personnel.

Mrs. ROGERS. You wanted it for years.

Dr. GRIFFITH. And we have advocated, as some of the consultants told you, since 1924 and 1925.

Mr. DOMENGEAUX. At this point may I ask a question?

When these medical consultants testified they said that since 1924 and every year thereafter, even in the present year, that they came to the conclusion that the present set-up was inadequate, that it resulted in securing undesirable doctors or not the very best doctors, and that this recommendation for a change of medical policy had been submitted to the Veterans' Administration since 1924 and repeatedly to this year. All of these consultants, doctors of the Veterans' Administration, made that statement. Now why is this something which has not been done in that regard? Mrs. Rogers has been interested for years in it and the Veterans' Administration discouraged it.

Mrs. ROGERS. I think the gentleman will find other sections of the Veterans' Administration opposed to study. I know when I talked to them since the beginning of the war they said: "Why should the medical have authority that the Administration does not have?" That is their testimony.

Mr. DOMENGEAUX. Who is responsible for not having this done since 1924, contrary to the recommendations of your advisory board?

Mrs. ROGERS. I do not know that Dr. Griffith would want to answer that question.

Mr. ODOM. I think General Hines will speak fully on that matter when he comes before the committee.

Mr. DOMENGEAUX. The gentleman may answer the question.

Dr. GRIFFITH. General Hines can answer.

Mr. DOMENGEAUX. Has the Medical Department of which you are the head made such a recommendation to General Hines or to your superior, Colonel Ijams?

Dr. GRIFFITH. The Medical Service has been on record as advocating a corps since 1925.

Mrs. ROGERS. I think it was 1925.

Mr. DOMENGEAUX. The Medical Service?

Dr. GRIFFITH. Yes.

Mr. DOMENGEAUX. I want to place responsibility if there is any.

Dr. GRIFFITH. I think the Administrator can give the answer.

Mr. AUCHINCLOSS. Can you give the answer?

Dr. GRIFFITH. Of course, the recommendations, Congressman, were submitted to General Hines.

Mr. AUCHINCLOSS. Can you answer the question or not?

Dr. GRIFFITH. About this corps, sir?

Mr. AUCHINCLOSS. Yes.

Dr. GRIFFITH. Apparently the Administrator did not want it.

Mr. AUCHINCLOSS. The Administrator did not want it. Is that the answer?

Dr. GRIFFITH. That would be my answer.

Chairman RANKIN. He wants the corps now.

Dr. GRIFFITH. I think he does, but I would rather General Hines would answer that question. Now, Mr. Chairman—

Mr. DOMENGEAUX (interposing). This may be an unfair conclusion, but it seems to me that when an organization of this kind headed by a medical department has an advisory board, that advisory board certainly deserves much consideration when they make a recommendation.

Mr. GIBSON. He said he was in favor of it.

Mr. SCRIVNER. That was 20 years ago.

Chairman RANKIN. How long have you been under civil service?

Dr. GRIFFITH. Since World War I. Now I might make a statement. The day before yesterday I told about our difficulties. I only touched the high spots of securing personnel from the Civil Service Commission. I would like to submit for the record the various channels we have to go through to get it.

Chairman RANKIN. Without objection it may be inserted in the record.

(The statement is as follows:)

On July 3, 1940, the Administrator was informed that an effort to fill medical vacancies for associate physicians, medical and hospital service, had exhausted the Civil Service register and that there were still approximately 50 vacancies. A register of at least 100 eligibles, it was understood, was available and that register was requested. However, it was pointed out to the Administrator in the memorandum of July 3, 1940, that in requesting registers from the Commission there had been a delay of from 4 to 6 months from the time of the closing of the examination to the time that the register became available to the Veterans' Administration and that a large percentage of the physicians certified were undesirable and that a very serious situation regarding medical personnel was beginning to arise. The Administrator's attention was also invited to the fact that on June 29, 1940, the American Medical Association had appointed a committee on medical preparedness and that committee had tabulated all the physicians in the United States for the purpose of determining how many would probably be best suited for Army, Navy, or civilian duty. It was then requested that a conference be held with the Army and Navy in order that a plan might be worked out whereby personnel on active duty with the Veterans' Administration could be left intact in the event of general mobilization were the Nation actually to enter into the war.

The Army and Navy were both expanding rapidly and it was considered that the situation confronting the Veterans' Administration would become still more acute when disabled veterans during the period of the emergency were added to the World War I load.

It was also pointed out that it was understood from the Personnel Division that the Civil Service Commission had been placed on a 24-hour basis with the armed forces to secure personnel for the various organizations and if the Civil Service Commission had, in the past, been swamped with too much work then it meant that the Veterans' Administration would suffer even more in securing service from the Commission.

It was also suggested at that time that consideration be given to securing authority from the President for the Medical Service to solicit and obtain associate physicians meeting at least the same standards of requirements under civil service.

On March 20, 1941, the Administrator was informed that the plan for employment of 100 additional physicians had not been accomplished as only 50 out of the civil-service registers that were available at the time actually accepted the appointment. Therefore, plans were immediately made to bring in another

group by May 1, 1941. Two civil-service registers were looked over—one containing 149 names and the other 129 names. Judging from the returns that were coming in from the selections it was believed that the administration would be fortunate if we were to obtain 75. Therefore, authority to take on an additional number of associate physicians, should they become available, was requested. The physicians did not become available.

In a memorandum to the Administrator written on March 20, 1941, it was pointed out to the Administrator that informal contact between the Medical Director and the Surgeon General of the Army indicated that the Army had carefully cataloged and made arrangements to commission in the Reserve Corps all graduates of medical schools of the year 1941 who would be acceptable to the Army professionally and physically.

It was also pointed out in that memorandum that in addition to this, on January 20, 1940, Dr. Irwin S. Cutter, dean, Northwestern Medical School, was contacted relative to the Medical and Hospital Service having a representative present at a meeting of the deans of medical schools in Chicago during February of 1940 so that opportunities for physicians in the Veterans' Administration might be presented. In reply to that letter the Medical Director was advised by Dr. Cutter that inasmuch as the Civil Service Commission was having a representative speak on that program and as Veterans' Administration physicians are selected from civil-service registers, and owing to the number of papers that would necessarily have to be presented on other subjects, it was not believed that opportunity could be made available to the Veterans' Administration to appear on the program.

It was also pointed out in the same memorandum to the Administrator that in the middle of February 1941 the Medical Preparedness Committee met in Chicago and at that meeting the Army, Navy, United States Public Health Service were represented but not the Civil Service Commission and that, therefore, it appeared that the interests of the Veterans' Administration required further representation either directly or through the Civil Service Commission, and that apparently the Civil Service Commission had taken no action to that effect up to that time.

There follows a letter of November 19, 1943, which was prepared in the Medical and Hospital Service, signed by the Administrator, and directed to the Honorable Paul V. McNutt, which relates the experience that the Veterans' Administration had had with the Procurement and Assignment Service from October 28, 1941. This letter, it is believed, throws considerable light on the problems with which the Veterans' Administration has been confronted in the procurement of an adequate number of medical officers.

"This has reference to my letter of June 8, 1943, which was in reply to your letter of June 2, 1943, and indicated that I would be very glad to discuss with you the serious physician-recruitment problems confronting the Veterans' Administration and stated that I would leave the selection of the date upon which the discussion was to be held to meet your convenience.

"On October 28, 1941, a meeting of a commission to draft a program for a Procurement and Assignment Agency was held at Washington, D. C., at which the Medical and Hospital Service of the Veterans' Administration was represented. A review of the copy of the minutes of that meeting indicates that the following statement was submitted by a representative of the Medical and Hospital Service: 'That 300 additional physicians will be required by the Veterans' Administration for the present fiscal year, to take care of replacements and expansion; 100 would be needed by January 1, 1942, and the remainder by June 30, 1942. If hostilities were to develop, this estimate would be increased immediately. These are permanent positions, not just for the duration of the emergency. The Veterans' Administration employed 15 new dentists last year and will need about 12 more for the coming year. In the official report of this meeting it was stated that the Veterans' Administration now has about 1,800 physicians in full-time positions. Approximately 500 of these hold commissions in the Medical Reserve Corps of the United States Army.'

"On November 19, 1941, a communication was directed to Hon. Paul V. McNutt, Administrator of Federal Security Agency, designating Dr. Hugo Mella, Assistant Medical Director, to represent the Veterans' Administration in the deliberations of the Procurement and Assignment Service. On November 26, 1941, at a meeting of the Procurement and Assignment Service the official representative of the administration stated that there was an acute shortage of 100 physicians and for the fiscal year ending June 30, 1942, the total number of physicians required under present needs was 210; 12 dentists were needed for this period. For the



fiscal year 1943, 300 additional physicians would be required and in the event of expansion of the Army the needs of the Veterans' Administration would be immediately increased. This appears on page 14 of the report of the meeting held on November 26, 1941.

"In the proceeding of meeting of directing board, Procurement and Assignment Service, held on January 9, 1942, statements appear from the Army and Navy representatives that the armed forces would not draw upon the Veterans' Administration for medical personnel. The representative of the Veterans' Administration also stated that physicians could be taken into the Veterans' Administration on a temporary basis, if necessary, and then it appears that the Medical Director of the Civil Service Commission was advised to proceed with the continuation of their recruitment methods until such time as the Procurement and Assignment Service was in a position to not only assist in their recruiting program, but to obtain professional clearances if desired and availability clearances through the Procurement and Assignment Service State chairman.

"At no time since January 9, 1942, has the liaison officer of the Veterans' Administration been asked to be present at a meeting of the Procurement and Assignment Service, although he advises that he has frequently been in contact with that Service by telephone on questions that have arisen on individual cases.

"On November 27, 1941, a letter was forwarded to the Chairman of the War Manpower Commission advising him of the need for physicians in the Veterans' Administration. No reply having been received, a follow-up letter was forwarded on January 8, 1942. The executive officer of the Procurement and Assignment Service replied to that letter stating that he believed that he would be in a position to report within 30 days; however, no results were obtained. The letter communication had reference to results of a survey made by the use of a medical enrollment form by the Procurement and Assignment Service, one of which, it is understood, was forwarded to every recognized physician in the country. Since it is understood that the returned copies were processed by the Procurement and Assignment Service for those who expressed preference for Army and Navy service first, it has not been possible to obtain a list of those who made a fourth choice; namely, one of the United States Civil Service agencies, which includes the Veterans' Administration.

"On February 20, 1943, I directed a letter to the Chairman of the War Manpower Commission in which I requested that I be advised as to whether in the arrangements accomplished by the War and Navy Departments with class A medical schools, the effort of these arrangements was measured in relation to the functions and needs of the Veterans' Administration, and what assurance may be given the Veterans' Administration prospectively in effecting replacements in its medical personnel. Your letter of March 25, 1943, stated that it would be difficult to change the situation at the moment.

"I replied to your letter of March 25, 1943, on April 3, 1943, requesting again that I be advised as to whether in the arrangements accomplished by the War and Navy Departments with class A medical schools the effect of these arrangements was measured in relation to the the functions and needs of the Veterans' Administration and again asked what assurance might be given to the Veterans' Administration prospectively in effecting replacement in its medical personnel. It was in reply to that letter that you suggested a personal discussion. On September 15, 1943, the Medical Director discussed with the executive officer of the Procurement and Assignment Service the immediate great need for physicians in the Veterans' Administration and as a result of that conference I directed a communication to Commander M. E. Lapham outlining the immediate need for physicians to cover existing vacancies and additional beds that are now being placed in service.

"I understand that as a result of this contact that a few names of physicians have been submitted to the Medical Director and contacts have been made with them, resulting in about three responses. In a letter of November 12, 1943, the names of seven physicians were forwarded who, it was thought, might be available, and Commander Lapham, executive officer of the Procurement and Assignment Service states that it would appear that at the present time no additional physicians are available.

"In order that appropriate steps may be taken to protect the interest of the disabled veterans entrusted to the care of the Veterans' Administration, it is requested that I be advised whether the War Manpower Commission can or cannot make an adequate number of physicians available to the Veterans' Administration at this time and also whether it will be possible to have a proper portion

of the newer graduates from class A medical schools allotted to the Veterans' Administration."

On March 27, 1942, the following letter, directed to the President, respectfully recommending Army commissions for medical officers in the Veterans' Administration.

"I have the honor to inform you that a grave situation has arisen in the Veterans' Administration in the maintenance of adequate medical care for disabled veterans of the present and previous wars. The average daily hospital patient load of approximately 60,000 is constantly increasing and the release of the physicians on duty in the Veterans' Administration to serve in the armed forces is creating a serious problem.

"To date 129 physicians have been called to active military duty, 131 medical officers have been found physically qualified and are awaiting orders, and 152 have been ordered to report for physical examination. The group of medical officers awaiting orders and those ordered for physical examination, totaling 273, will, according to the advice received from the Secretary of War in his letter dated February 11, 1942, be released to the Army on April 1, 1942. This will make a grand total of 412 doctors so far released or available for military service. In addition, there are 606 doctors now in the service of the Veterans' Administration who are of draft age. This number added to 412 makes a total of 1,018 doctors potentially available for service with the armed forces.

"To meet urgent present requirements, there are 76 doctors available in Veterans' Administration training schools and 18 doctors are under orders to report on April 1, 1942, for a course of training, which would leave a deficit of 318 released or available to the armed services without replacements, for the reason that civil-service registers have been practically exhausted as far as appreciable numbers are concerned.

"It is desired to emphasize that many of the full-time physicians of the Veterans' Administration who presently hold commissions and who, it is understood, are to be called by the Army on April 1, 1942, are filling positions which are not only of key nature, but replacements would require years of training. This includes medical administrative positions and the specialties, such as psychiatry, neurology, eye, ear, nose and throat, surgery, orthopedics, pathology, roentgenology, urology, cardiology, and oral surgery.

"The source of supply of qualified physicians has sustained serious inroads by the Army and Navy medical services, and is nearing the exhaustion point if there are to be a minimum number of physicians available for civilian activities, such as the practice of medicine and the necessary staffs for medical schools responsible for training additional physicians. It is understood that the Army and Navy are recruiting students as quickly as they are accepted for admission to medical schools so that they may be commissioned as medical officers promptly upon graduation. Therefore, that source is becoming extremely arid.

"It appears that under existing laws, blanket deferments from selective service for groups such as physicians may not be granted, it being possible to make appeals in individual cases only. This would be an extremely difficult procedure to pursue as of this date certain isolated selective-service boards have denied deferment to physicians now serving with the Veterans' Administration unless the physicians agree to apply for a commissioned status in the Army or Navy.

"To correct this condition, it is recommended that immediate action be taken by blanketing into the Army of the United States in a commissioned status, all physicians in the Medical and Hospital Service in central office and in hospitals of the Veterans' Administration as well as those whom it will be necessary to employ as replacements for any who have been lost to the armed services and any who may be separated through death or other causes. It is recommended that this be accomplished and that the officers who thereby will have been commissioned be placed on a detached-service status in the Veterans' Administration under the jurisdiction of the Administrator of Veterans Affairs, to hold the grade in which they are commissioned but remain on the pay roll of the Veterans' Administration at their present salaries, or the salary of the position to which it may become necessary to promote them as vacancies occur in the service and also to retain their civil-service benefits. This, of course, would necessitate for this group a change in age limits presently required by the Army as to retirement and a definite reduction in physical requirements as presently exist for field service in the Military Establishments. As the physicians placed on a detached service with the Veterans' Administration would be serving in our hospitals within the continental confines of the United States, the service would



be limited and would preclude the rigid military requirements for field service.

"If it is possible to commission the physicians in the Veterans' Administration and place them in a detached service, at their present salaries, basing the comparable rank on the minimum grade in which a medical officer is commissioned, namely, first lieutenant, equivalent to the P&S-3 group, there would be 253 first lieutenants and 744 captains, equivalent to the P&S-4 group. In addition, there would be 400 training positions, 250 of which would be in the first lieutenant or associate physician group and 150 in the P&S-4 or captain group, making a total of 503 first lieutenants and 894 captains. There would also be 465 majors in the P&S-5 grade, 162 lieutenant colonels in the P&S-6 grade, 42 colonels in the P&S-7 grade, and 1 brigadier general in the P&S-8 grade; the latter grade having reference to the Medical Director.

"Having in mind the morale of our medical officers, it will be appreciated that it would be entirely impracticable to effect commissions on the basis of present Army pay and allowances for the reason that their current annual civil-service salaries are at rates which greatly exceed those attached to the grades recommended.

"Included in these groups are full-time medical officers of the Medical and Hospital Service only. It is proposed that fee basis and part-time consultants be continued on a civilian status.

"In submitting this, may I respectfully suggest the urgency of the situation in that under existing instructions of the Secretary of War as presented in his letter of February 11, 1942, all Reserve officers will be considered available to the Army as of April 1, 1942."

As a result of this, medical officers in the Veterans' Administration who voluntarily applied were granted commissions equivalent to the civil-service grade held at the time. However, this did not satisfy the younger medical officers and a number of those in the upper age brackets, so it was pointed out to the Administrator in a memorandum of September 5, 1942, that within 60 days 26 medical officers had submitted their resignation from the Veterans' Administration so that they could enter active military service. This number, plus the usual number resigning to enter private practice and the average loss by retirement and death, resulted in a more critical situation, particularly so in that the medical profession at that time had been under terrific pressure not only over the radio and in medical journals but also in the newspaper, to apply for active duty with the armed forces.

Not until December 16, 1943, was a directive issued by the War Department authorizing active duty for the medical officers who had been commissioned and could qualify for such active duty.

It is believed that it should also be pointed out here that on August 28, 1944, a letter was directed by the Administrator to Dr. Frank H. Labey, chairman of the directing board, Procurement and Assignment Service, stating that only a very few physicians had become available to the Veterans' Administration through the Procurement and Assignment Service; also asking that he be advised whether the Procurement and Assignment Service could make available immediately to the Veterans' Administration 250 qualified physicians. The reply to this letter was directed to the Administrator on October 12, 1944, by the Honorable Paul V. McNutt as Chairman of the War Manpower Commission, expressing the hope that the Veterans' Administration would be able to obtain a higher percentage of men who were being declared available at that time. In other words, no assistance was obtained from that source.

The executive officer of the Procurement and Assignment Service notified the Administrator on November 11, 1944, that there would be a meeting of the directing board on November 25 and invited the Administrator to attend and also stated that the invitation, of course, included the right to bring with him any members of his staff who he desired to have present. The meeting was attended but no results as far as obtaining additional physicians resulted.

Approximately 399 medical officers left the Veterans' Administration to enter the armed forces. Of these approximately 100 who were serving with the Army in the zone of the interior have been returned to duty with the Veterans' Administration and in addition to this the Army has released approximately 275 military service medical officers who were no longer qualified to serve with troops in the field. There are on duty with the Veterans' Administration in the Medical and Hospital Service 2,010 physicians.

The Navy released approximately 50 medical officers to the Veterans' Administration but this group were practically all absorbed by the Adjudication Service



and of this group and the additional group commissioned for the Veterans' Administration by the Navy, gives a grand total of 17 commissioned officers of the Navy on duty with the Medical and Hospital Service at this time.

In addition to this there are approximately 15 first lieutenants who are in limited status because of physical handicaps and who will complete their internships approximately the latter part of June 1945 who will then be available to the Veterans' Administration and in addition to this approximately 35 men who will be available the 1st of October 1945.

Mr. SCRIVNER. What does that statement show?

Dr. GRIFFITH. Almost weekly conferences were held with officials of the Civil Service Commission and with the Administrator, and the Medical Service reported to the Administrator our shortages, our difficulties, and the quality and the quantity we were getting. The Administrator had much more faith in conferences, in what was promised by the Commission, than the rest of us did.

Mr. SCRIVNER. In other words, the Civil Service might promise that all vacancies would be filled, but they never kept their promises.

Dr. GRIFFITH. They assured the Administrator from time to time that they could get the personnel and the general believed them.

Mr. SCRIVNER. Did they make good?

Dr. GRIFFITH. No, sir.

Mrs. ROGERS. In other words, the Veterans' Administration would have placed the nurses in the professional class months ago?

Dr. GRIFFITH. We wanted the nurses in the professional class for years but the civil service or the classification put them in subprofessional, and after the general argued the matter with them for months and months and found he was not getting anywhere, finally he issued the order that as of July 1, they will go into the professional status.

Mrs. ROGERS. I asked a hearing before the Ramspeck committee on the bill I introduced and I haven't been given the courtesy of a hearing as yet. Dr. Parran is very much interested in the same bill.

Chairman RANKIN. Doctor, there are one or two questions I would like to ask you.

Has the Civil Service Commission opposed this Medical Corps in the Veterans' Administration during all these years?

Dr. GRIFFITH. I cannot answer definitely; they have been rather vague about it but I do not think they were enthusiastic for it.

Chairman RANKIN. All right.

Mr. McQUEEN. Speaking of nurses going on a different status: For instance, we had a great many complaints, particularly over my desk, in regard to nurses in Dayton, Ohio. I think some twenty-odd nurses at Dayton, Ohio, have complained of the fact that they had been ordered moved from Dayton to other facilities or as nurses in regional offices; and it seems from the letters that these nurses are nonregistered nurses.

Dr. GRIFFITH. That is right.

Mr. McQUEEN. Now is it a fact that under the new arrangement which you have put into effect as of the 1st of July, that you could not use a nurse who is not registered in the hospital as of that time?

Dr. GRIFFITH. Before we consolidated with the national homes, every one of the homes had their own yardstick of selecting nurses.

Chairman RANKIN. When was that?

Dr. GRIFFITH. It was before 1930.

Chairman RANKIN. When?

Dr. GRIFFITH. It was before 1930.

Chairman RANKIN. When did that consolidation take place?

Dr. GRIFFITH. July 1, 1930, they combined the national homes with the veterans' facilities and the nurses in the national homes were not under civil service; and after we consolidated, they blanketed all of those nurses in, and through an oversight on everybody's part—at least that of the Veterans' Administration—we thought they were all graduate nurses. No one ever thought otherwise. Apparently the civil service did not catch it.

Now I have known for 2 years that there was something wrong at Dayton, and I tried every way in the world to find out and I had my troubles. I sent nurses down there and I knew they would not stay. Then I finally took it up with the State director of nurses in Ohio and got her to tell me why we could not have cadet nurses there, and she told me that we had 14 or 16 nonregistered nurses who could not meet the requirements of the State board of examiners in their own States, and that they had graduated from inferior schools in the State of Ohio and maybe some other States; I do not know.

Mr. McQUEEN. But they have been on duty there for years.

Dr. GRIFFITH. They have been on duty there since 1925, I think.

Mr. McQUEEN. And they were blanketed in.

Dr. GRIFFITH. They were blanketed in when we consolidated.

Mr. McQUEEN. That was in 1930?

Dr. GRIFFITH. Yes, sir.

Mr. McQUEEN. And they are still at this moment nonregistered nurses?

Dr. GRIFFITH. Yes, sir; and they have not graduated from an accredited, registered nursing school, but we want it understood that many of them have rendered very good service.

Mr. McQUEEN. And every nurse after July 1 in Dayton will be a registered nurse.

Dr. GRIFFITH. Right.

Chairman RANKIN. Dayton was a Federal soldiers' home before it was taken over in 1930?

Dr. GRIFFITH. Yes, sir.

Chairman RANKIN. And these nurses were there serving in their various capacities?

Dr. GRIFFITH. Yes, sir; as nurses. They were on duty.

Chairman RANKIN. Veterans of the Civil War and Spanish-American War?

Dr. GRIFFITH. And also of World War I.

Chairman RANKIN. And when we took it over in 1930 these nurses were blanketed in?

Dr. GRIFFITH. That is right; not only at Dayton but in all of the homes.

Chairman RANKIN. I understand there has been so much said about Dayton, Ohio, and I wanted to get it in the record. Why did we pick that particular place?

Dr. GRIFFITH. Practically all of those nurses have rendered very good service. Many of them will be ready for retirement in a year or so. If we would discharge them outright, they could not practice anywhere else in Ohio or in any other State.

Mr. RAMEY. Some of those nurses are in charge of wards by themselves, where they have 15 or 20 attendants on night duty.

Dr. GRIFFITH. That is right.

Mr. RAMEY. They are rendering very good service.

Dr. GRIFFITH. Yes, sir; I want it understood that those nurses have given good nursing.

Mr. RAMEY. Each nurse has charge of a whole ward.

Dr. GRIFFITH. Yes, sir; but the cadet nurses program under the State directors, that will not permit those cadet nurses to serve under and work under a nonregistered nurse.

Mr. McQUEEN. Any more than a doctor could be permitted to practice who was not a graduate of a first-class school.

Dr. GRIFFITH. Exactly.

Chairman RANKIN. But some of the best doctors practicing in the United States did not even enter medical school.

Dr. GRIFFITH. There is something to that.

Chairman RANKIN. And if the same rule applied to the legal profession, I seriously doubt if Blackstone and I doubt if even John Marshall could practice.

Dr. GRIFFITH. I do not care to comment on that.

Mrs. ROGERS. The nurses have performed a very unselfish service since the war.

Dr. GRIFFITH. I haven't anything but praise for the service that the nurses have given.

Mrs. ROGERS. I know you feel that way.

Mr. RAMEY. There are quite a number of young nurses doing good work there.

Dr. GRIFFITH. Yes, sir.

Mr. RAMEY. But the trouble is there needs to be more of them as there are not enough to do all the work that they have to do, including the dispensing of medicine. They have an unusual burden.

Dr. GRIFFITH. That is right.

Chairman RANKIN. Are there any further questions of the doctor?

Mrs. ROGERS. Doctor, you still have a board, and on that board you have Dr. Dublin and Dr. Overholzer. Is that correct?

Dr. GRIFFITH. Dr. Overholzer was for some time on the Federal Board for Hospitalization.

Mrs. ROGERS. Why isn't he on it?

Dr. GRIFFITH. General Hines is a member of the Board. I am not a member and I prefer to have you ask the general about that.

Mrs. ROGERS. Well those men have not been called for a good many years to give advice.

Dr. GRIFFITH. It has been some time.

Mrs. ROGERS. Why is that?

Dr. GRIFFITH. Well, of the original group, six or seven of them are dead.

Mrs. ROGERS. Why weren't they called to give advice?

Mr. BENNETT. I would like to know why were not the vacancies filled.

Dr. GRIFFITH. We created a new board. We appointed additional men.

Mrs. ROGERS. Did you dismiss them?



Dr. GRIFFITH. No; they are subject to call and I have used a number of them on the TB, NP, and so forth.

Mrs. ROGERS. Can you give us the names of some of them?

Dr. GRIFFITH. I use Dr. Patterson quite frequently up in New York State, and all of this group that was over here the other day, they are all members of the original board, practically all of them.

Mrs. ROGERS. Dr. Monroe was one of your consultants?

Dr. GRIFFITH. We tried to appoint him and Dr. Monroe balked on salary. The doctor was down several days ago and we wanted to use him as a consultant in Boston. I wanted to use his services and the doctor said he would not work for what the Government paid.

Mrs. ROGERS. Did you want him to go all over the country?

Dr. GRIFFITH. He said he would not work for \$25 a day and traveling expenses.

Mrs. ROGERS. He performed this miracle operation on a very famous baseball player and the man is able to play baseball again.

Dr. GRIFFITH. Now, Mr. Chairman, I gave the total number of consultants and I would like for record purposes here to have it shown broken down by States.

Chairman RANKIN. May I look at this (examining exhibit).

Without objection it will be inserted in the record at this point.

(The data are as follows:)

Palo Alto, Calif.:		Whipple, Ariz.:	
Internist, fee-----	1	Surgery, fee-----	1
Eye, ear, nose, and throat, fee--	1	Eye, ear, nose, and throat, fee--	1
Surgery, fee-----	1	Tucson, Ariz.:	
Neurosurgeon, fee-----	1	Surgeon, fee (chest)-----	1
Alexandria, La.:		Bronchoscopic, fee-----	1
Chest Surgeon, part-time-----	1	Boise, Idaho:	
Washington, D. C.:		Chest surgery, part-time-----	1
Chief Consultant, part-time---	1	Chest surgery, fee-----	1
Internists, part-time-----	7	Anesthetist, part-time-----	1
Eye, ear, nose, and throat,		Spinalgrams, fee-----	1
part-time-----	1	Bedford, Mass.:	
Eye, part-time-----	3	Internal medicine, fee-----	1
Neuropsychiatrists, part-time---	5	Genitourinary surgery, fee---	1
X-ray and pathology, part-		Dermatology, fee-----	1
time-----	3	Eye, ear, nose, and throat,	
Neurosurgeons, part-time-----	3	part-time-----	1
Surgeon, part-time-----	4	Surgery, part-time-----	1
Urologist, part-time-----	2	X-ray, fee-----	1
Genitourinary, part-time-----	2	Neuro-surgery, fee-----	1
Orthopedic surgeons, part-		Northport, Long Island, N. Y.:	
time-----	3	Surgery, fee-----	1
Dermatology, part-time-----	1	Neurosurgery, fee-----	1
Gynecologist, part-time-----	2	Fargo, N. Dak.:	
Bronchoscopist, part-time-----	1	X-ray, fee-----	1
Oral surgery, fee-----	1	Eye, ear, nose, and throat,	
Perry Point, Md.:		part-time-----	1
Surgeons, part-time-----	2	Orthopedic surgery, fee-----	1
Atlanta, Ga.:		Neurology, part-time-----	1
Dermatologist, fee-----	1	Lyons, N. J.:	
Internist, fee-----	1	Neurology and surgery, fee---	2
Oto-rhinolaryngology broncho-		Dermatology, fee-----	1
scopy, fee-----	1	Coatesville, Pa.:	
General medical, fee-----	10	Surgery, part-time-----	1
General medical, part-time-----	2	Pathology, part-time-----	1
Tumor, part-time-----	1		
Oral surgeon-----	1		

<b>Lincoln, Nebr.:</b>		<b>Portland, Oreg.—Continued</b>	
Neurology, fee.....	1	Orthopedic surgeon, fee.....	2
Eye, ear, nose, and throat, fee.....	2	Dermatologist, fee.....	1
Surgery, fee.....	2	Urologist, fee.....	1
Orthopedic surgery, fee.....	1	Thoracic surgeon, part-time.....	1
Neuropsychiatrist, fee.....	1	Dermatologist, fee.....	1
General medicine.....	1	Ear, eyes, nose, and throat, fee.....	2
<b>Boise, Idaho:</b>		Internist, fee.....	1
Surgery, fee.....	1	X-ray, part-time.....	1
Ear, eye, nose, and throat, fee.....	1	<b>North Little Rock, Ark.:</b>	
Urology, fee.....	1	Ear, eye, nose, and throat, part-time.....	1
<b>Knoxville, Iowa:</b>		Urologist, fee.....	1
Ear, eye, nose, and throat, part time.....	1	X-ray, fee.....	1
Internist, fee.....	1	Orthopedic surgeon, fee.....	1
<b>Oteen, N. C.:</b>		Surgery, fee.....	1
Chest surgeon, fee.....	1	Dermatologist, fee.....	1
Urologist, part-time.....	1	Internal medicine, fee.....	1
<b>Augusta, Ga.:</b>		Neurologist, fee.....	1
X-ray, fee.....	1	<b>Outwood, Ky.:</b>	
GU, fee.....	1	Surgeon, fee.....	1
Internist, part-time.....	1	Anesthetist, fee.....	1
Surgery, fee.....	2	<b>Fort Lyon, Colo.:</b>	
Neurosurgeon and neurology, fee.....	1	Surgeon, part-time.....	1
<b>Lake City, Fla.:</b>		<b>Bronx, N. Y.:</b>	
X-ray, fee.....	1	Consultant in treatment of tumors, part-time.....	1
<b>Fort Harrison, Mont.:</b>		Consultant in surgery, part- time.....	1
Orthopedic surgeon, fee.....	1	Consultant in histopathology, part-time.....	2
Ear, eye, nose, and throat, fee.....	1	Ophthalmologists, part-time.....	1
<b>Gulfport, Miss.:</b>		Otolaryngology, part-time.....	1
Surgeons, fee.....	2	Vascular disease, part-time.....	1
Ear, eye, nose, and throat, fee.....	1	Eye, part-time.....	1
<b>Hines, Ill.:</b>		Psychoanalysis, part-time.....	1
Head and neck surgeon, part- time.....	1	Dermatologist, part-time.....	1
Consultant in tumors, part- time.....	1	Cardiologist, part-time.....	1
Neurologists, part-time.....	2	Neurosurgeon, part-time.....	1
Gastroenterologist, part-time.....	1	Plastic surgeon, part-time.....	1
Thoracic surgeon, part-time.....	1	Thoracic surgeon, part-time.....	1
Ophthalmologist, part-time.....	1	General medicine and internal medicine, fee.....	13
Proctology, part-time.....	1	<b>Sheridan, Wyo.:</b>	
Internal medicine, part-time.....	2	Surgeon and pathologists, part- time.....	1
Dermatologist, part-time.....	1	Surgeon, fee.....	1
Orthopedist, part-time.....	1	Ear, eye, nose, and throat,.....	1
Neuropsychiatrists, part-time.....	2	<b>Memphis, Tenn.:</b>	
Pathologist, part-time.....	1	Surgeon, part-time.....	1
General surgery, part-time.....	1	Ear, eye, nose, and throat, fee.....	1
Gynecologist, fee.....	1	<b>Rutland Heights, Mass.:</b>	
Gastroscopist, part-time.....	1	General surgeon and Urologist, part-time.....	1
Consultant, tropical diseases, fee.....	1	Thoracic surgeons, alternating.....	4
Internal medicine, fee.....	2	<b>Muskogee, Okla.:</b>	
Surgeon, fee.....	1	Surgeon, orthopedics, part- time.....	1
Vascular disease, part-time.....	1	Genitourinary diseases, fee.....	1
Internal medicine.....	1	Ear, eye, nose, and throat, fee.....	1
<b>Portland, Oreg.:</b>		<b>Batavia, N. Y.:</b>	
X-ray and deep ray, fee.....	1	Eye, fee.....	1
Pathologist, part-time.....	1	Ear, eye, nose, and throat, fee.....	1
Surgeon, part-time.....	1	Surgeon, fee.....	1
Radium therapy, part-time.....	1		
Neuropsychiatrist, fee.....	1		

Bath, N. Y.:		Fayetteville, N. C.:	Eye, ear, nose,	
Internist, part-time	1	and throat, fee		1
Urologist, fee	1	Fort Howard, Md.:		
Surgeon, part-time	1	X-ray, fee		2
Orthopedic surgeon, fee	1	Neuropsychiatric, fee		3
Bay Pines, Fla.:		Orthopedic surgeons, fee		4
Ear, eye, nose, and throat, fee	1	General surgeons, fee		5
Nervous and mental, fee	1	Psychiatrists, fee		3
Biloxi, Miss.:		Gastroenterology, fee		1
Urologist and pathologist, fee	1	Anesthetist, fee		1
Ear, eye, nose, and throat, fee	2	Tuberculosis and heart, fee		1
Tropical diseases, fee	1	Cardiovascular, fee		1
Brecksville, Ohio:		Dermatologist, fee		1
General medicine and diagnosis, fee	1	Hot Springs, S. Dak.:		
Urology, fee	1	General medical, fee		1
Neuropsychiatric, fee	2	Consultants in surgery, alternating, fee		3
Orthopedic surgeon, fee	1	Kecoughtan, Va.:		
Cheyenne, Wyo.:		Urologist, part-time		1
Pathologist, part-time	1	Surgery, fee		1
Eye, part-time	1	Pathologist, fee		1
Urologist, fee	1	Los Angeles, Calif.:		
Ear, nose, and throat, part-time	1	Surgeons, part-time		2
X-ray, fee	1	Urologist, part-time		1
Surgeon, fee	2	Dermatologist, part-time		1
Dallas, Tex.:		Eye, part-time		1
Diseases of lung, fee	1	Ear, nose, and throat, part-time		1
Genitourinary, fee	1	Neurosurgeon, part-time		1
Rectal surgeon, fee	1	Tumor, diagnosis, part-time		1
Eye, ear, nose, and throat, fee	1	Thoracic surgeon, part-time		1
Pathologist, fee	1	Thoracoplastic surgery, part-time		1
Dermatologist, fee	1	Eye, ear, nose, and throat, fee		1
Gynecologist, fee	1	Internal medicine, fee		2
Roentgenologist, fee	1	Oral surgeon, fee		1
Danville, Ill.:		Montgomery, Ala.:		
Urologist, part-time	1	Pathologist, part-time		1
Roentgenologist, part-time	1	Eye, ear, nose, and throat, fee		3
Dayton Ohio:		Diseases of the chest, fee		1
Orthopedist, fee	1	General medicine, fee		1
Dermatologist, fee	2	Pathologist, fee		1
Pathologist, fee	1	Mountain Home, Tenn.:		
Surgeon, fee	1	Ear, eye, nose, and throat, fee		1
Internist, fee	1	Urology, part-time		1
Urologist, fee	1	Surgeon, part-time		1
Eye, ear, nose, and throat, fee	1	Murfreesboro, Tenn.:		
Dearborn, Mich.:		Surgeon, part-time (1 alternate)		1
Pathologist, fee	1	Ear, eye, nose, and throat, fee		1
Radiologist, fee	1	Urology, fee		1
Genitourinary, fee	1	Roseburg, Oreg.:		
Orthopedic fee	2	Consultant in surgery, fee		1
Eye, ear, nose, and throat, fee	2	Ear, eye, nose, and throat, fee		1
Neuropsychiatrist, fee	1	San Francisco, Calif.:		
Tuberculosis, fee	1	Dermatologist, fee		1
Cardiologist, fee	1	Ophthalmologist, fee		3
Dermatologist, fee	1	Rental diseases, fee		1
Des Moines, Iowa:		Neuropsychiatrists, fee		3
Eye, ear, nose, and throat, fee	3	Neuro surgeons, fee		3
Urology, fee	1	Diseases of the chest, fee		3
Surgery, fee	1	Otolaryngologist, fee		1
Tuberculosis, part-time	1	Gastroenterologist, fee		2
Dermatology, fee	1	Proctologist, fee		1
Fayetteville, Ark.:		X-ray, fee		1
General medical, fee	1			
Surgeon, fee	1			



San Francisco, Calif.—Continued		American Lake, Wash.—Continued	
Cardiologists, fee.....	2	Eye, ear, nose, and throat, fee.....	1
Ear, eye, nose, and throat, fee.....	4	Surgery, fee.....	1
Orthopedic, fee.....	6	Neurosurgery, fee.....	1
Pathologist, fee.....	3	Northampton, Mass.:	
Urologists, fee.....	4	Surgery, part-time.....	1
Gynecologist, fee.....	2	Eye, ear, nose, and throat, part-time.....	2
Endocrinology, fee.....	1	Roentgenology, fee.....	1
Surgeons, fee.....	2	Sunmount, N. Y.:	
Anesthetists, fee.....	3	Surgery, fee.....	1
Dean of consultants, part-time.....	1	Anesthetist, fee.....	2
Togus, Maine:		Chillicothe, Ohio:	
Surgeon, fee.....	1	X-ray, part-time.....	1
Ear, eye, nose, and throat, fee.....	1	Surgery, fee.....	2
Wadsworth, Kans.:		Internal medicine, fee.....	1
Surgeon, part time.....	1	Eye, ear, nose, and throat, fee.....	2
X-ray, part-time.....	1	Neurosurgery, fee.....	1
Ear, eye, nose, and throat.....	1	Chest surgery, fee.....	1
White River Junction, Vt.:		Orthopedic, fee.....	1
Eye, ear, nose, and throat, fee.....	1	Castle Point, N. Y.:	
Surgery and urologist, fee.....	1	Thoracic surgery, part time.....	1
Surgeons, fee.....	2	Surgery, fee.....	1
Wichita, Kans.:		Fort Custer, Mich.:	
Neuropsychiatrist, fee.....	1	Surgery, fee.....	3
Diseases of the chest, fee.....	1	Internal medicine, fee.....	2
Eye, ear, nose, and throat, part-time.....	2	X-ray, fee.....	1
Surgeon, part-time.....	1	Orthopedic and traumatic fee.....	1
Radiologist, part-time.....	1	Eye, ear, nose, and throat, fee.....	1
Urologist, fee.....	1	St. Cloud, Minn.:	
Wood, Wis.:		Orthopedic and traumatic, fee.....	1
Facial surgeon, fee.....	1	Survey and urology, fee.....	1
Eye, nose, and throat, fee.....	2	X-ray, fee.....	1
Urologist, part-time.....	1	Neurosurgery, fee.....	1
Internist, fee.....	1	Livermore, Calif.:	
Surgeon, fee.....	1	Surgery, part time.....	1
Orthopedic surgeon, fee.....	1	Neuropsychiatry, fee.....	1
Dermatologist, fee.....	1	Bronchoscopy, fee.....	1
Neurologist, fee.....	1	Anesthetist, fee.....	1
Proctologist, fee.....	1	Aspinwall, Pa.:	
X-ray, fee.....	1	Pathology and bacteriology, part time.....	1
Reno, Nev.:		Genitourinary disease, part time.....	1
Eye, ear, nose, and throat, fee.....	1	Test surgeon, part time.....	1
Internal medicine, fee.....	1	Urology and neurosurgery, fee.....	1
General surgery, fee.....	1	Neurology, fee.....	9
Pathologist, fee.....	1	San Fernando, Calif.:	
Surgeons, fee.....	2	Thorocoplastic surgery, part time.....	1
Surgeon, part-time.....	1	Anesthetist, fee.....	1
Neuropsychiatrist, part-time.....	1	Dōwney, Ill.:	
Jefferson Barracks, Mo.:		Surgery, fee.....	1
Plastic surgeon, fee.....	1	Surgery, part time.....	2
Urology, fee.....	1	Ear, nose, and throat surgery, fee.....	1
Dermatology, fee.....	1	Minneapolis, Minn.:	
Surgery, fee.....	1	Surgery, part time.....	1
Eye, fee.....	1	Orthopedics, part time.....	1
Ear, nose, and throat, fee.....	1	Newington, Conn.:	
Neuropsychiatry, fee.....	1	Cardiology, fee.....	2
Legion, Tex.:		Orthopedic, fee.....	1
Test surgery, fee.....	1	Urology, fee.....	2
Anesthetist, fee.....	1	Neuropsychiatry, fee.....	3
American Lake, Wash.:		X-ray, fee.....	2
Roentgenology, fee.....	1	Pathology, fee.....	1
Pathology, fee.....	1		
Surgery, part-time.....	1		
Internal medicine, fee.....	1		
Genitourinary and skin, fee.....	1		

Newington, Conn.—Continued		Amarillo, Tex.:	
Eye, ear, nose, and throat, fee	1	Surgery, fee	1
Eye, ear, nose, and throat, part time	1	Eye, ear, nose, and throat, fee	1
Orthopedic surgery, fee	2	West Roxbury, Mass.:	
General surgery, fee	2	Spinal, fee	1
Bone and joint surgery, fee	1	Neurology, fee	2
Lexington, Ky.:		Pathology, fee	1
Nerology, fee	1	Surgery, fee	1
Eye, ear, nose, and throat, fee	1	Orthopedics, fee	1
X-ray, fee	1	Urology, fee	1
Pathology and bacteriology, fee	1	Neurosurgery, fee	2
Ophthalmology, fee	1	Albuquerque, N. Mex.:	
Surgery, fee	2	Surgery, fee	1
Cardiology	1	Urology, fee	1
Indianapolis, Ind.:		Thoracic surgery, fee	1
Tuberculosis and neuropsychiatry, fee	1	Neuropsychiatry, fee	1
Eye, ear, nose, and throat, fee	1	Pathology, fee	1
Surgery, fee	2	Salt Lake City, Utah:	
X-ray, fee	1	Orthopedic surgery, fee	2
Neuropsychiatrist, fee	1	Surgery, part-time	6
Neurosurgery, fee	1	Internal medicine and cardiology, fee	3
Ophthalmology, fee	1	Neuropsychiatry, fee	1
Orthopedic surgery, fee	2	Eye, ear, nose, and throat, fee	3
General medicine, fee	1	Roentgenology, fee	1
Marion, Ind.:		Neuropsychiatry and brain surgery, fee	1
Surgery, part time	1	X-ray, fee	1
Eye, ear, nose, and throat, part time	2	Gynecologist, fee	1
Canandaigua, N. Y.:		Ophthalmologist, fee	1
Surgery, fee	1	Gastroenterologist, fee	1
X-ray, part time	1	Proctology, fee	1
Neurology, fee	1	Tuscaloosa, Ala.:	
Waco, Tex.:		Surgery, fee	2
Surgery, part time	2	Huntington, W. Va.:	
Eye, ear, nose, and throat, fee	1	Urology, fee	1
Urology, fee	1	Internal medicine, fee	1
Dermatology and syphilology, fee	1	Orthopedic surgery, fee	1
Tuberculosis, fee	1	Eye, ear, nose, and throat, fee	2
Mendota, Wis.:		Columbia, S. C.:	
Surgery, fee	3	Dermatology, fee	1
Optomalogy, fee	3	Orthopedic, surgery, fee	2
Neuropsychiatry, fee	2	X-ray, fee	2
Internal medicine and endocrinology, fee	1	Urology, fee	1
Diseases of the chest, fee	1	Eye, ear, nose, and throat, fee	1
X-ray, fee	1	Internal medicine, part time	1
Allergy, fee	1	Neuropsychiatrist, fee	3
Neurosurgery, fee	1	Neurosurgery, fee	1
Urology, fee	1	Roanoke, Va.:	
Radiology, fee	1	General medicine, fee	2
Obstetrics and gynecology, fee	1	Internal medicine, fee	2
		Neuropsychiatrist, fee	1
		Genito-urinary diseases, fee	1

Mr. DOMENGEAUX. This is not on the trend you are testifying to now, Doctor, but will you tell me whether I was correct in the conclusions I drew when I visited the TB hospital with some 1,200 beds in North Carolina?

Dr. GRIFFITH. Congressman, you are about 75 percent right.

Mr. DOMENGEAUX. I found approximately 35 doctors, 50 percent of whom were doctors who had been discharged by the Army.

Dr. GRIFFITH. And they were afraid of tuberculosis.

Mr. DOMENGEAUX. Some of those doctors detailed by the Army, I found that a large percentage of them had tuberculosis, that they were completely disgusted with their assignment, and this tuberculosis which some of them really had; and that all resulted in bringing about a more depressed condition among the patients in that hospital. Would you say that is the true picture of the situation?

Dr. GRIFFITH. Pretty much so; yes, sir.

Mr. DOMENGEAUX. Then I found among the older doctors a crew who were headed by Dr. Beverly, the medical director.

Dr. GRIFFITH. No; I suppose he led you to believe he was.

Mr. DOMENGEAUX. What was he?

Dr. GRIFFITH. Chief of medical service.

Mr. DOMENGEAUX. In other words, he had been with the Veterans' Administration many, many years and he headed the group, and that group was completely dissatisfied with the management; and he gave me his testimony, which, if you like, I shall read. Well, it is quite a long statement, but generally you will admit that the circumstances, some of which were brought about by the war or by the assignment of these doctors, and others by dissatisfaction among the personnel, resulted in a condition that was most detrimental to the welfare of the patients.

Dr. GRIFFITH. In the main I agree, and that is why we changed the administration and put a new manager and clinical director there.

Mr. DOMENGEAUX. I will read one part of it. I could question you on this for hours. I have a letter from three very fine young ladies who have been nursing in the Veterans' Administration for many years and these are some of the things they said:

They are now TB cases, having contracted the disease while employees of the Veterans' Administration.

Dr. GRIFFITH. They contracted the disease of tuberculosis while on duty.

Mr. DOMENGEAUX. This is a general statement, which is very long, of the case, in regard to how they contracted tuberculosis. They had nice surroundings and were only interested in bettering the general situation.

Chairman RANKIN. They were criticizing the conditions at that hospital and told how they contracted tuberculosis at other hospitals at which they were nursing?

Mr. DOMENGEAUX. That is correct.

Chairman RANKIN. Were they criticizing the hospitals where they contracted tuberculosis?

Mr. DOMENGEAUX. They were criticizing the entire policy and the medical treatment of tuberculosis, the lack of training of the doctors, and inability, inadequate sterilization of equipment; the failure properly to educate the patient in self-treatment and advising him what he should do to reduce the period of his illness, and educational training along that line. They are very complete about it.

Dr. GRIFFITH. Those girls must have been very careless or they would not have contracted the disease.

Mr. DOMENGEAUX. I do not know.

Dr. GRIFFITH. Any doctor or any nurse, when they take up their profession as a medical officer or a nurse, subject themselves to con-



tracting communicable diseases, if they treat patients having such diseases. Now if these nurses were so efficient they should have known how to protect themselves.

Mr. DOMENGEAUX. That may be true, except I do not think it is. These nurses were not in tuberculosis hospitals but in general hospitals in which there were tuberculosis wards and beds.

Dr. GRIFFITH. That is right, but they came in contact with cases of tuberculosis and they contracted it.

Mr. DOMENGEAUX. That is very true; I grant it—but the fact that they contracted tuberculosis does not disqualify them from making observations.

Dr. GRIFFITH. No; it does not.

Mr. DOMENGEAUX. But I think it gives some weight to their observations on their experiences in hospitals. I do not think they disqualified themselves by reason of the fact that they contracted tuberculosis.

Dr. GRIFFITH. No; it does not disqualify them.

Mrs. ROGERS. And isn't it true, also, that these nurses may have met with something which was not sterilized without knowing it—such as tableware which was not clean?

Mr. DOMENGEAUX. That is right. They knew the regulations, but they were speaking generally of conditions in TB hospitals, not with reference to the situation when they contracted the disease.

Chairman RANKIN. Doctor, you did not include leprosy in your list of tropical diseases.

Dr. GRIFFITH. Yes, sir; and also sprue.

Chairman RANKIN. Now we are warring in a tropical country and in a country where there is a good deal of tropical diseases.

Dr. GRIFFITH. Congressman, we have soldiers in every country in the world and they can contract every type of disease known to the profession.

Chairman RANKIN. Have you special grades of servicemen who have been unfortunate enough to have contracted leprosy?

Dr. GRIFFITH. No; but we have six or seven designated hospitals.

Chairman RANKIN. Where are they?

Dr. GRIFFITH. Here, New Orleans, Chicago, San Francisco, and Los Angeles.

Chairman RANKIN. Have you any cases of leprosy?

Dr. GRIFFITH. Not that I know of. They would have been reported if we had any.

Chairman RANKIN. Have you a cure for leprosy?

Dr. GRIFFITH. No.

Chairman RANKIN. What do you know about the treatment Chaulmugra oil?

Dr. GRIFFITH. It has been rather successful. It is not a cure but it is the best thing we have.

Chairman RANKIN. It has cured some.

Dr. GRIFFITH. That is true; you do not know when you are cured from leprosy.

Chairman RANKIN. It is my understanding that Chaulmugra treatment has been very successful and patients who have taken it have not had a return of the disease.

Dr. GRIFFITH. I think that is correct, sir, over a period of years.

Mr. RAMEY. You mentioned Dayton, Ohio, a while ago. I want to follow that up a little. At the Dayton Hospital you have at the head one of the finest surgeons of the country.

Dr. GRIFFITH. Dr. Bergman.

Mr. RAMEY. He is one of the best surgeons in this country.

Dr. GRIFFITH. We think so.

Mr. RAMEY. And the manager is Mr. Ale, who came to Dayton from Indianapolis where he had 20 years of service.

Dr. GRIFFITH. That is right.

Mr. RAMEY. There are expressions used by folks who move from one place to another and they say they are going to "Siberia." So some people say when they are going to a harder job that they are going to Siberia, and doctors have said that they were sent to Siberia when they were sent to what was not as good a place as they were then occupying.

Dr. GRIFFITH. That is right. There are about five other hospitals in that group.

Mr. RAMEY. Here is the situation: Dayton has made it very difficult for our committee. I was there three times. After leaving there, I asked a lady whose husband was in the service and who was an engineer, not a doctor, who is the State treasurer of the American Legion Auxiliary in Ohio at Dayton, to work voluntarily after I left and interview veterans of World War II.

Dr. GRIFFITH. Yes, sir.

Mr. RAMEY. She did report three complaints, and she reported something like 50 times as many who said that they were treated well. I reported these complaints here because one man said when they were in the hospitals overseas, they were well taken care of, but when they got here, they were forgotten men. I asked further about it and he said they were just shoved around and do not get the attention or recognition, and no attention or medical service.

Now when this lady made reports on those 3, she also made reports on about 50 times as many who all said they had very good service and were very well satisfied with the service. Now one man wrote an anonymous letter from the hospital and said that they were treated like dogs. Now unfortunately a letter like that receives the attention of the entire country, whereas those letters from people who say they have received very good treatment receive no attention. Now just what is the reason why we do not get actual reports on the good service as well as the bad?

Dr. GRIFFITH. I was going to comment on that. I would say 98 percent of our patients get excellent treatment, but if 1 percent complains and gives out a flat statement without supporting it with proof, that is advertised.

Mr. RAMEY. The only one who made the report that they were treated like dogs sent an anonymous letter to the committee, and that was the only letter that reached the headlines.

Dr. GRIFFITH. That is right, and it makes it very unfortunate for the management to face that criticism.

Mr. RAMEY. The great difficulty is that there is a want of attendants at hospitals all over the country and there is not sufficient help.

Dr. GRIFFITH. That is right.

Mr. RAMEY. And then I think when we discuss doctors we should discuss nurses; and yet at the same time we have not discussed attendants very much.

Dr. GRIFFITH. That is right.

Mr. RAMEY. It is the attendants that complain that unfortunately the doctors and the nurses talk with an imperious voice. It is difficult to get attendants now and they are the ones who receive the unusually harsh treatment. They just cannot understand why they are ordered around in the manner that they are, and as a result they quit. The fact is the attendants do not get much of a wage.

Don't you think that when we have our boys to take care of, that the attendants should be young men, veterans of World War II, so that our attendants will be big brothers and make a career of it?

Dr. GRIFFITH. Congressman, attendants have always been underpaid. It is a dirty job that the attendant has to do and you can name it anything you want to. You can classify it any way you want to, but he must wash urinals, empty bed pans, and do drudgery, and all that work has to be done by somebody.

Mr. RAMEY. And they are ordered by the doctors and nurses who have professional standing. Instinctively they rebel. They say: "Everybody is giving orders and we have to do the work."

Dr. GRIFFITH. That work must be done and somebody must do it, and you can name it anything you want to and it is still the same job.

Mr. RAMEY. If it was made a career, it probably would change the picture. After all, they are the folks who are with the veterans constantly, whereas the doctor may be with the patient 5 minutes or an hour.

Dr. GRIFFITH. The attendant is the pick-and-shovel boy who does the dirty work.

Mr. ODOM. I think there is an implication that should be cleared up. Mr. Ale was transferred, and by the way, it was a promotion, wasn't it?

Dr. GRIFFITH. I think it was.

Mr. ODOM. Mr. Ale did not stay where he had been for many years in Indianapolis where there was easy work.

Mr. RAMEY. He was sent to this place where a new building was put on a barn.

Mr. ODOM. I thought you would want that explained. One other thing I want explained—a question by Congressman Auchincloss. Isn't it true, Doctor, that under the law you have no authority to offer any gratuities, or cash rewards, or anything of that kind for engaging in research?

Dr. GRIFFITH. That is right.

Mr. ODOM. But Congress under the law specifically authorizes you to pay the expenses of that work; and, of course, the one who takes advantage of it and proceeds to profit by it would also profit by way of promotion in due course of time.

Dr. GRIFFITH. That is right; we do not give cash rewards. We have no authority of law to do it.

Mr. BENNETT. Have you been unable to draw contracts with doctors in order to keep them on their job?



Mr. ODOM. I think you can draw a contract that would be a basis for damages if canceled—you would hold them.

Mr. SCRIVNER. Could we end this on a little more pleasant note?

During the Easter recess when I went home, I spoke to an overflow meeting at a hospital. I do not know how many were there, but well over 200. I made inquiry of them as to how many had ever been patients in a veterans' facility, and I expect 90 to 95 percent indicated by their hands that they had been patients, and I followed that by a question:

All right; those of you who have been patients in veterans' facilities, how many of you have any complaints to make about any treatment you have received?

I received not one single complaint.

Mr. DOMENGEAUX. Mr. Scrivner, do you consider that there is no question but what the veterans get everything in the way of first-class attendance in first-class plants? But what patient is really qualified to say whether he gets good care?

Mr. SCRIVNER. Why, he comes out in that improved condition. He knows the condition in which he was when he went there. I think those men are men of mature years, and I know them well enough and they know me well enough that they do not have to put on any curves when they shadow-box me. They can tell the plain truth and they will tell me when they won't tell anyone else.

Mr. DOMENGEAUX. I wonder how the average individual can determine whether he gets competent medical care.

Mr. SCRIVNER. I think he can. The average individual knows what was his condition when he entered the hospital and he also knows whether or not there has been an improvement when he leaves.

Chairman RANKIN. The person decides whether he is receiving good treatment when he gets well.

Dr. GRIFFITH. That is a good yardstick, Mr. Chairman.

Chairman RANKIN. If a patient is cured of his trouble, why he certainly is competent to say he had proper treatment.

Dr. GRIFFITH. That is a very good yardstick. May I add this statement?

I am on a committee on postwar training and education. A questionnaire was sent to practically all the doctors overseas or in the military service, asking what they wanted to do after the war: how much training, how much postgraduate work, whether they wanted to go in the Federal service, the Army, the Navy, Public Health, or VA; and what type of special training did they want to take. I think there were some 40,000 questionnaires that went out to the young military doctors and the committee has received back a large percentage of replies. The analysis shows there are only 2 percent going to take neuropsychiatry and a fraction, 2.5 percent, is going to take up tuberculosis.

Chairman RANKIN. Doctor, there have been several million patients pass through these hospitals.

Dr. GRIFFITHS. That is right.

Chairman RANKIN. What percentage, would you say, have complained to the Veterans' Administration in regard to the treatment given them?

Dr. GRIFFITH. Approximately 2 percent.

Chairman RANKIN. Ninety-eight percent had no complaints whatever!

Dr. GRIFFITH. Mr. Chairman, it would take a truck to haul over here and present to you the letters commending the Administration, appreciative letters of the treatment and service rendered.

Chairman RANKIN. There is another thing that I do not think the other members of the committee have had to deal with. I get letters that pour in on me from every State in the Union. There are one or two chronic kickers always writing me about something, and since this has come up it has been a field day for them.

Dr. GRIFFITH. I can understand that.

Chairman RANKIN. May I inquire what the program for the rest of the day is? Are you through, Doctor?

Mr. SCRIVNER. I would like if you could designate what the program would be and when we will resume hearings this afternoon.

Chairman RANKIN. I thought that when we finished with the doctor, we would adjourn until 1 or 1:30.

Mr. SCRIVNER. I would suggest resuming the hearing at 1:30.

Mr. DOMENGEAUX. Will the doctor be back?

Chairman RANKIN. Not if you are through with him.

Mrs. ROGERS. Isn't it a fact that doctors are susceptible to tuberculosis?

Dr. GRIFFITH. Any run-down condition makes you subject to tuberculosis.

Mrs. ROGERS. I know of hospitals where many of the nurses contracted tuberculosis. They were civilian hospitals. Now do you train personnel to be tuberculosis nurses; that is, do you give a special course?

Dr. GRIFFITH. No, I cannot answer that question. Perhaps Miss Andrews could answer it better than I could.

Mrs. ROGERS. Is it not true that very few training schools give student nurses any training in the care of tuberculosis patients?

Dr. GRIFFITH. It is quite difficult to give them any special training, Mrs. Rogers.

Mrs. ROGERS. Has the Tuberculosis Association ever given approval of what they considered essential or proper education and training in caring for tuberculosis patients?

Dr. GRIFFITH. I think in this development training course she is warned and instructed how to avoid tuberculosis and how to take care of herself.

Mrs. ROGERS. She has no special training?

Dr. GRIFFITH. Not that I know of.

Mr. McQUEEN. Mr. Chairman, I have one or two questions that I would like to ask the doctor.

Doctor, can you state for the record approximately how many beds under the present program have been completed and are ready for occupancy without your having the personnel to man those hospitals?

Dr. GRIFFITH. Mr. McQueen, I would have to go and count up the various hospitals; because, you see, you have a floor in this hospital vacant because you do not have the personnel, maybe 50 beds—but I do know that there are 2,600 beds coming in in the next 30 or 60 days that I do not have personnel to handle.

Mr. McQUEEN. During the recess last week I made a visit to Wadsworth, Kans., and I was delighted with what I found. I found that

hospital had been increased by 2,065 beds for NP patients but there was only one building that had any patients in it. Naturally I asked why, and they told me that the hospital is ready for occupancy on the first day of July but they have no personnel, either doctors, nurses, or attendants, to man that hospital.

Dr. GRIFFITH. There are four hundred-odd beds available at said hospital, but those beds, they do not have sufficient personnel to man the hospitals and it is not manned yet. The Army gave us recruits to go in there.

Mr. McQUEEN. One hundred fifty.

Dr. GRIFFITH. I think that is correct.

Mr. McQUEEN. And I might add that the reports show that they were getting along very fine with those 150. They asked for 350 but could get only 150.

Dr. GRIFFITH. I understood on this point system of operation of the hospitals from a military standpoint that the War Department cannot give us any more troops.

Mr. McQUEEN. There is one other question. I want you to state to the committee and for the record the interference that you have had from lay personnel or lay officials in the management of your hospitals and in the general over-all administration of the medical department.

Dr. GRIFFITH. Do you mean outsiders?

Mr. McQUEEN. No, I mean within the administration.

Dr. GRIFFITH. I do not know that we have any; very little.

Mr. McQUEEN. Have you had any?

Dr. GRIFFITH. Not that I can recall.

Mr. McQUEEN. If you have had any, state that for the record.

Dr. GRIFFITH. We always have a lot of people, both inside and out, trying to tell us how to do the job.

Mr. McQUEEN. Have you had any discussions or have you had any interference from anybody over you in your department in the management and operation of the hospitals?

Dr. GRIFFITH. Do you have reference to any difficulties or interference on the part of Assistant Administrators?

Mr. McQUEEN. Yes, sir.

Dr. GRIFFITH. I function through an Assistant Administrator, Colonel Ijams. The colonel has leaned over backward not to dictate in clinical medicine or tell me how to run things in medicine. On administrative problems he might not agree with what I suggest, but he has always taken my side of the story; and if we could not agree, we would submit it to the Administrator, and he would settle the argument.

Mr. McQUEEN. Have you had any trouble in getting to the Administrator with your recommendations and desires as to the operation of the hospitals themselves in your medical department?

Dr. GRIFFITH. Colonel Ijams has repeatedly given me promises, and, if I wanted to see the Administrator, I can see him by myself or otherwise.

Mr. McQUEEN. Still, in view of what you say here, are you still of the opinion that the medical department should be under an Assistant Administrator directly responsible to the Administrator? Is that right?



Dr. GRIFFITH. Let us state that this way: We feel that if legal and other agencies can report direct to the Administrator, that the medical department can, too.

Mr. McQUEEN. You said a while ago you wanted to take up this bill, which proposed reorganization of the medical department, and I do not believe you did. I think the chairman would like to hear about it now.

Mr. DOMENGEAUX (acting chairman). The gentleman from Missouri [Mr. CARNAHAN] would like to ask a question.

Mr. CARNAHAN. I want to submit for the record an article from the Arkansas Democrat by Mr. Karr Shannon, under date of June 1, 1945, and a second article by the same author under date of June 3, 1945. One of the articles deals with the veterans' facility at North Little Rock, and the other one deals with the Arkansas State Hospital, which is also located at Little Rock.

These two articles furnish a very good basis of an unbiased comparison between veterans' facilities and State institutions, and for the convenience of those who might want to read them, I would like to give just a few of the figures.

At the veterans' hospital there were 1,509 patients, and in the Arkansas State institution there were 4,471 patients.

At the veterans' hospital there were 20 doctors, which is a ratio of 1 doctor to approximately 75 patients, according to these articles.

Dr. GRIFFITH. That is about correct, sir.

Mr. CARNAHAN. At the State institution there were 8 doctors, or 1 doctor for 600 cases.

In nursing, at the veterans' facility there were 55 nurses, which is 1 to 26, and at the State institution there were 6 graduate nurses, or approximately 1 for each 745 patients.

In regard to attendants, at the veterans' facility there were 242 attendants, or a little less than 1 attendant to 7 patients. In the State institution there were 213 attendants, or 1 attendant for about each 21 patients.

The veterans' facility spends \$2.37 a day per patient, and the State institution spends 74 cents a day per patient.

These articles were written by Mr. Karr Shannon, and I believe that the information he gives is accurate. I have been to both those institutions, and I think these reports are in agreement with what I saw.

Mr. DOMENGEAUX. Dr. Griffith, do you know Dr. Hugh Henry, at Biloxi, Miss.?

Dr. GRIFFITH. Very well.

Mr. DOMENGEAUX. He has been the surgeon there for how many years?

Dr. GRIFFITH. Well, he has been at Biloxi for several years.

Mr. DOMENGEAUX. Do you consider him an average doctor in the Veterans' Administration?

Dr. GRIFFITH. I would rather not answer that.

Mr. DOMENGEAUX. Would you care to comment on that? I have a letter from Dr. Henry, after I had visited there in the Easter holidays in which he said, among other things:

I could give you some real interesting sidelights on third-rate medicine in the Veterans' Administration.

That is one of your doctors who has been there for many, many years. I do not think he is dissatisfied.

Dr. GRIFFITH. I should say he is much, very much dissatisfied, and he is waiting until the first of the year when he is eligible to retirement.

Mr. DOMENGEAUX. I think he is a very kindly, fair man. That was my observation of the man.

Mr. CARNAHAN. I certainly do not want to have you infer that I am offering any criticism of the institutions at Little Rock, Ark. I have visited both and I think they are both doing fine work. I especially want to commend Dr. Kolk, superintendent of the State hospital, for the fine work I think he is doing there with the amount he has to do it with.

Dr. GRIFFITH. Congressman, I think your ratios of personnel and per diem costs are accurate, although I have no way of knowing the situation of the State institution, but I know that your figures are accurate and they are on a ratio of personnel and per diem.

Mr. CARNAHAN. Of course, that is not my statement, but I visited those institutions this year.

I would like to have these articles in the record.

Mr. DOMENGEAUX. Without objection they will be inserted in the record at this point.

(The articles above referred to are as follows:)

[From the Arkansas Democrat, Sunday, June 3, 1945]

#### RUN OF THE NEWS

(By Karr Shannon)

#### VETERAN HOSPITALS SCORED

An article in the May issue of Reader's Digest on Veteran Betrayed—Our Mental Casualties, portrays horrible conditions and overcrowding in Federal Government supported mental hospitals for veterans of this country.

"Already more than 10,000 mentally wrecked veterans of this war have been 'shoehorned' in beside nearly 30,000 from the last war who still haunt our 30 veterans' mental hospitals," the article said. "Every month the overcrowded wards become more crowded still—while others wander our cities untreated or cynically discharged as 'unimproved.'"

"There is no excuse for this situation," the article continues. "Long ago, Congress ruled that all veterans—the mentally disabled included—were entitled to the finest care that modern medicine can provide."

And then gobs of data and incidents are produced to show that veterans in these hospitals receive brutal treatment, have incompetent medical staffs, etc. Specific information was given concerning at least half dozen of the larger hospitals in the country.

Thereupon I requested some information from Col. D. D. Campbell, manager of the Veterans' Administration, relative to the institution located in North Little Rock—which was not mentioned in the Reader's Digest article.

His reply, in part, is as follows:

#### FORT ROOTS WELL STAFFED

"This hospital, being primarily for the treatment of neuropsychiatric diseases, is staffed and equipped with that in view. The physical equipment for the clinical activities of the hospital is adequate, with the following special diagnostic and treatment departments: General medical, surgical, dental, clinical, and X-ray laboratories, physical therapy, pharmacy, electrocardiographic and electroencephalograph departments, elctroshock and insulin therapy, occupational and industrial therapy.

"The medical staff is composed of 18 physicians and 2 dentists. In unusual medical conditions that may arise among the patients, consultants are available from the city of Little Rock and the University of Arkansas Medical School. There is a consultant available in each of the following specialties: Neurosurgery,

general surgery, orthopedic surgery, internal medicine, eye, ear, nose, and throat, dermatology, and neurology. The nursing staff is composed of 1 chief nurse and 54 staff nurses, 1 supervisor of attendants, and 241 attendants.

"The hospital has an official bed capacity at present of 1,847 beds. The completion of the 4 new ward buildings now under construction will increase our capacity to approximately 2,400 beds.

#### HAS 1,500 PATIENTS

"As of April 1, 1945, there were 1,509 patients resident in the hospital. Of these, about 400 were veterans of World War II. Total admissions for 1944 were 1,217; total discharges 1,222, of which 894 were discharged as either recovered or improved.

"Appreciation of the tremendous load with which Veterans' Administration is confronted with the advent of World War II would enable you to understand the difficulties with which we are confronted, and the time must be allowed to organize and systematize the work. Until such time as this can be accomplished there is bound to be some delay in functioning to our fullest capacity. That the Veterans' Administration is capable of overcoming these difficulties has been demonstrated by the record of the administration since World War I. The treatment that is being given at Fort Roots and other hospitals in the Veterans' Administration will compare favorably with that being given in any institution of a like nature, State or private, in the United States."

#### COMPARISON OF COSTS

The hospital at Fort Roots was recently investigated, and Colonel Campbell said, and given a clean bill of health. Colonel Campbell states the investigator said that in his opinion they were "doing a fine job."

The Reader's Digest article said the Federal Treasury pays out, for every patient on the rolls of the veterans' mental hospitals, \$2.24 per day. Colonel Campbell said the average cost per day per patient at Fort Roots is \$2.37.

Colonel Campbell's prompt response to request for information about his institution is highly appreciated. A request for somewhat similar information relative to medical staff, nurses, number of patients, number of beds, and cost per patient per day in the State hospital here has been made, but to date no information has been received.

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[From the Arkansas Democrat, June 16, 1945]

#### RUN OF THE NEWS

(By Karr Shannon)

#### THE STATE HOSPITAL

Not long ago I published in this column some facts about Fort Roots, in North Little Rock, after an article in the Reader's Digest gave a review of Government-operated mental hospitals for veterans.

For the purpose of comparison, I have contacted Dr. A. C. Kolb, superintendent of the State hospital, about the work of Arkansas' institution.

"The total patient population of the State hospital, which is composed of three units, Little Rock, Benton, and the dairy farm at Baucum, is 4,762," Dr. Kolb said. "The medical staff is composed of a superintendent, clinical director, and assistant superintendent. We have 7 ward physicians and 1 dentist, also 6 graduate nurses and 213 ward attendants. The ratio is 1 physician to every 680 patients. The ratio of ward attendants to patient population is 1 for every 24 patients. We have 4,471 patient-beds, with about 300 patients sleeping at night on mattresses on the floor in the halls.

"This condition will be remedied when the new building is constructed at the Benton unit this year. The War Production Board has already approved application for construction.

"The State hospital has an operating room and a laboratory, both equal to anything in the city. The following equipment is used in the examination, diagnosis, and treatment of patients: A basal metabolism machine, electrocardiograph, two shock therapy machines, X-ray, two artificial fever cabinet machines,



and other general medical, surgical, dental, and clinical equipment. In addition to these treatments, physiotherapy, hydrotherapy, occupational therapy, and industrial therapy are used. The institution employs a specialist in eye, nose, and throat, neurosurgery, general surgery, orthopedic surgery, and other consultation service which is necessary."

#### HAS MAJOR PROBLEMS

Dr. Kolb pointed out that during 1944 there were 1,813 patients admitted to the hospital; 608 patients returned to the hospital who had been given a conditional discharge. During the same period, 229 patients were discharged and 1,329 conditionally discharged.

"During the last 4 years there has been a turn-over in the employee personnel each year of more than 100 percent," Dr. Kolb explained. "This will give you an idea of the problem with which we have had to deal."

Making his estimate from the regular appropriations, Dr. Kolb said, the cost per patient per day to the taxpayers is 74 cents. "This includes every expense of the hospital," he said.

"In addition, the hospital has to clothe at least half the patient population and has to bury approximately 30 percent of the patients who die in the institution," Dr. Kolb continued. "No other institution in the State is required to render this extra service."

He estimated that on the basis of the last appropriation patients next year might be allowed a cost of 87 cents instead of 74 cents per day for treatment.

The cost per patient per day in the Federal hospital at Fort Roots is \$2.37. But in that institution there is an average of 1 physician to every 84 patients, instead of the 1 to 680 ratio in the State hospital. These figures might be considered a fair example of the difference in care and cost of treating patients in a State or Federal institution.

If the State hospital is not up to standard, the blame can be laid only to the State of Arkansas.

Mr. DOMENGEAUX. Dr. Griffith, then the charges of third-rate medicine come from within the Administration, not only from outside.

Dr. GRIFFITH. Yes, sir; that is right. Have you ever stopped to think, Congressman, why a doctor who has been in our service 20 or 25 years never progressed any further than a ward surgeon?

Mr. DOMENGEAUX. I don't see how he got employed as he did from the central office.

Dr. GRIFFITH. That is why we want a corps bill.

Mr. DOMENGEAUX. This doctor who is a surgeon—at that time he served the hospital, performing and being called upon to perform the most delicate operations of a very dangerous type. He went upon OD the day I got there at 8 o'clock in the morning and was to continue on OD until 8 o'clock the next day.

Dr. GRIFFITH. He went on at 8 o'clock at night.

Mr. DOMENGEAUX. He is a highly technical man, performing most valuable operative work, and yet he is called upon to do OD work. Do you think that is right for that type of a man—a head surgeon?

Dr. GRIFFITH. I did it for 10 years.

Mr. DOMENGEAUX. That is not the point.

Dr. GRIFFITH. You do it in the Army or Navy.

Mr. DOMENGEAUX. I say a man who is on OD duty all night might be called upon to perform a most delicate operation.

Dr. GRIFFITH. That is his specialty.

Mr. DOMENGEAUX. And no man who is called upon to do that function is in a position to do the best work, from a surgical standpoint. We have noted that has been the policy of the whole Administration.

Dr. GRIFFITH. That is right; and of the Army, Navy, and Public Health Service, as well as the Veterans' Administration.

Mr. DOMENGEAUX. Every doctor is called upon to do it, excepting clinical doctors and the manager.

Dr. GRIFFITH. And they are subject to call 24 hours a day.

Mr. DOMENGEAUX. That is some of the red tape.

Dr. GRIFFITH. I want to know just what you thought about red tape.

Mr. DOMENGEAUX. I can give you other cases. Dr. Beverly, who has been with you for many, many years, told me 65 to 70 percent of his time and the time of the doctors was spent on red tape—paper work.

Dr. GRIFFITH. I am glad you brought up paper work.

Mr. DOMENGEAUX. Have you spent that much time on paper work?

Dr. GRIFFITH. There is a cure for some of that paper work, and the cure is to get trained clerical help that can take dictation from the doctors. We need trained clerical help to take the reports of the doctors. We were ready to put such a plan in effect, but when the war came we found we could not get enough stenographers to do it.

Mr. DOMENGEAUX. That has always been the case. Do not blame it on the war.

Dr. GRIFFITH. I grant you; you have got to make those reports. They are necessary for insurance purposes, for rating purposes, and for claims of all types, and for the record of the patients.

Mr. DOMENGEAUX. But primarily does not a patient go to the hospital for medical care?

Dr. GRIFFITH. Sure; but you must make recommendations for compensation, insurance, and all of that. I know that the paper work is a headache. I know it full well.

Mr. DOMENGEAUX. Those things may be necessary; I do not question it.

Dr. GRIFFITH. Nobody likes it, but tell me how you are going to get along without it.

Mr. DOMENGEAUX. I can give you a couple of illustrations. You could use dictaphones and secretaries.

Dr. GRIFFITH. We have a lot of dictaphones, a large number of them, but the doctors, many of them, do not like to use the dictaphones.

Mr. DOMENGEAUX. You need not put the doctors on boards checking up the statements of a patient falling out of bed, for example, and having abrasions, when an investigator can do that.

Dr. GRIFFITH. You have something there.

Mr. DOMENGEAUX. I have seen an average report. The patient falls out of bed and the orderly or the attendant has got to make a report. The nurse then must make a report. The doctor must make a report and the director, if there is an abrasion of any kind, it then has to be submitted to your investigating board consisting of three doctors; and they spend sometimes hours and even days on such an investigation. That is something certainly absolutely apart from their medical duties.

Mrs. ROGERS. Will the gentleman yield?

Is that your duty to decide, or the duty of Colonel Ijams, or of the Administrator, General Hines.

Dr. GRIFFITH. All.

Mrs. ROGERS. Who decides the amount of time given to those cases? That is not the duty of the Medical Director?

Dr. GRIFFITH. The Administrator. We have certain regulations that must be lived up to; not necessarily the Administrator, but Colonel Ijams or the Medical Director. There is a system which has grown up.

Mr. ODOM. May I ask a question?

Dr. Griffith, you stated that recently the Administrator issued a regulation purporting to relieve the medical personnel of a great deal of that investigative work.

Dr. GRIFFITH. And a special officer be in charge of it.

Mr. ODOM. But is it going to be possible in your judgment to determine in advance whether the medical profession should conduct the investigation or not?

Dr. GRIFFITH. Are you asking me?

Mr. ODOM. Yes.

Dr. GRIFFITH. He has got to investigate to find out.

Mr. ODOM. Therefore, can you relieve the doctors thereby?

Dr. GRIFFITH. No, sir.

Mr. ODOM. That is my conclusion, too.

Mrs. ROGERS. Dr. Griffith, are you responsible for the promotion of the doctors and the promotion of other employees or do other people act upon it?

Dr. GRIFFITH. I am glad you brought it up. The annual rating of each employee on a station is made up by a board appointed by a local manager, and that individual is rated by his superiors. Then it goes before the board; then that report is forwarded to Washington of the individual's efficiency record. There are about 14 to 16 points on it. It is a confidential record. It is a graphic record. The people on my staff have not one parcel of authority to change one iota on that rating.

Now each one of those ratings is given a relative rate and they are added up, and that is how the efficiency is arrived at.

Mrs. ROGERS. Who decides.

Dr. GRIFFITH. After it is all brought together: I will stick to doctors, for example. The manager sends a report in. I have a board composed primarily of three of the medical directors to go over it. They add it up and they give the weights or the weights that have already been given are approved and compared with the weights already given which have been approved by the Administrator, and it works out 85 or 90. Then they are checked through the Personnel Division and then it goes to the Administrator for approval.

Mrs. ROGERS. So that the head of the Personnel Division would handle the mechanical part of it for you?

Dr. GRIFFITH. Yes.

Mrs. ROGERS. But who has authority to make promotions? That is what I want to find out.

Dr. GRIFFITH. Now another thing on promotions: In order to get in the higher brackets, you have got to go into administration. The neurologist and the surgeon, they can only get up so high and then they stay. That is one reason why we want a classification.

Mrs. ROGERS. Dr. Griffith, in H. R. 3110, I think the resolution is, or in H. R. 3117, also at the end, there was what I call a joker in the bill which was not germane to the bill.

Dr. GRIFFITH. You are speaking about section 30?



Mrs. ROGERS. Yes.

Dr. GRIFFITH. Well, I do not know about that. Probably Mr. Odom could give you light on that.

Mr. ODOM. Mr. Chairman, the whole purpose of that was to get an able surgeon general and pay him more than \$10,000 a year, and also to pay the other chief staff members in the same salary range. At the present time under public laws you cannot employ these staff assistants of the Veterans' Administration and pay them more than \$10,000 a year, which is the top for civil-service employees. The sole purpose of that section, therefore, Mrs. Rogers, was to permit the Administration to employ not only a surgeon general but I think four or five other staff members at a salary range of \$10,000 to \$12,000 a year, so that you could get the right man to do the job.

Mrs. ROGERS. And legal counsel.

Mr. ODOM. Legal counsel might be worth as much as a doctor, I would say. I think the legal counsel, if properly qualified, should be worth as much as a doctor; that is, equivalent to the Judge Advocate General in the War Department.

Mrs. ROGERS. In the Medical Corps?

Mr. ODOM. This is in the Administration.

Mrs. ROGERS. I find then in this bill there is legal counsel for the Veterans' Administration and an assistant.

Mr. ODOM. Assistant Administrators for the VA.

Mrs. ROGERS. That is what I thought; then it probably did not belong in the Medical Corps bill. I would like to have the VA occupy a place in the Cabinet.

Mr. ODOM. You may recall in that regard the Medical Corps was taken out of the Cabinet bill. The whole point is this: You cannot take care of VA by taking care of the Medical Corps alone. While I am on my feet, Mrs. Rogers asked a question the other day—or rather she did not ask a question, but she expressed a fear that it might take too much authority from the Medical Service. Speaking as general counsel, I am sure you appreciate that no lawyer has any force or authority as such, except to the extent that his opinions are valid and sensible. The head of the administrative agency does not even have to pay any attention to his general counsel if he does not want to. He will likely get in trouble if he does not—and he may if he does.

Mrs. ROGERS. I do not think that belongs in the Medical Corps bill, but in the department bill, and I did not see it there.

Mr. ODOM. The necessity is to keep salaries in line.

Mr. CARNAHAN. Each year on the Hill they complain of the paper work doctors have to do.

Dr. GRIFFITH. That is right.

Mr. CARNAHAN. And a lot of it seems rather simple work of copying records.

Dr. GRIFFITH. The cure would be to have clinical clerks who can take dictation from the doctors on the physical examinations and make up their reports.

Mr. CARNAHAN. It looks like it is a position for a stenographer.

Dr. GRIFFITH. She has to be more than a stenographer. You know, it takes about 6 months to take a good general stenographer and train her to take medical dictation and take it accurately.

Mr. CARNAHAN. Have you such a facility in the VA?

Dr. GRIFFITH. We teach it to them; yes, sir.

Now one of the difficulties, if the doctor is making a physical examination or a mental, and primarily mental on a neurological or any specialized examination, he would not want to dictate out loud, verbally, everything in front of that patient. Now he does not have to do it, but if he uses a dictaphone he would. Now he can make his examination. He can make a few notes to be clear on the things which are important on completion of the first neurological or special examination. He has a stenographer in the office and can give the dictation in 10 or 15 minutes, but it is one of the most difficult things in the world because some stenographers never learn the terminology, particularly in the NP.

Mr. CARNAHAN. That is what I was thinking.

Dr. GRIFFITH. And if the stenographer does not get it right, the whole thing is wrong.

Mr. CARNAHAN. That is right; it must be a correct record.

Dr. GRIFFITH. Yes, sir.

Mr. CARNAHAN. My feeling is that you should have a special rating for those people, a higher rating than they would get for regular stenography.

Dr. GRIFFITH. Well, then, you get in this difficulty, that you would have to have a special rating for the stenographers that make engineering or legal reports.

Mr. CARNAHAN. We are interested in what you are going to do in the Veterans' Administration.

Dr. GRIFFITH. I brought that up from the Veterans' Administration standpoint. I am heartily in favor and endorse that there be some trained stenographers to take dictation and the mechanics of it can be worked out very easily. We endorse that and it will save the doctors a great deal of their time.

Mr. CARNAHAN. I think it will be money well spent. A stenographer of that type would save many hours of the doctors' time.

Dr. GRIFFITH. It would save 50 percent of the doctors' time. And then on expenditures for patients' clothing, you must sign your name so many times for a pair of socks or a necktie or a shirt, so that the manager is busy.

Mr. DOMENGEAUX. Who makes these regulations?

Dr. GRIFFITH. Some come from the finance and others come from other groups.

Mr. DOMENGEAUX. Why shouldn't that be corrected?

Dr. GRIFFITH. I do not know.

Mr. DOMENGEAUX. I want to ask one question. I do not know who has been running the medical department of the Veterans' Administration, but as I understand it the medical college, the voluntary group of outstanding men.

Dr. GRIFFITH. That is right.

Mr. DOMENGEAUX. And your department has recommended these reforms that are incorporated in this bill for many, many years?

Dr. GRIFFITH. That is right.

Mr. DOMENGEAUX. Now, do you know any medical opposition to this, from any source, that was given to the Administrator?

Dr. GRIFFITH. Do you mean from any outside agencies, any source at all?

The only man who can answer that question is General Hines.

Mr. DOMENGEAUX. Well, on the information that we have it is not reasonable to conclude that the medical policy has been determined and set up on this major problem by laymen and not by doctors?

Dr. GRIFFITH. General Hines is a layman; General Hines is the Administrator.

Mr. DOMENGEAUX. Yes.

Dr. GRIFFITH. And General Hines is the head of the Veterans' Administration. There are five other branches besides the medical.

Mr. DOMENGEAUX. Would you say there is any difference between the Administrator and the Secretary of War with his staff?

Dr. GRIFFITH. No.

Mr. DOMENGEAUX. However, the Secretary of War does take the opinion of his advisers or specialists of the department to which they are assigned, and in this case the general's technical advisers have made recommendations since 1925 and he has neglected to follow the advice of his advisers.

Dr. GRIFFITH. It was since 1925, Congressman.

Mr. DOMENGEAUX. And since that time no attention has been given to the recommendations of the medical advisers?

Mr. ODOM. We will give you some information on that.

Mr. McQUEEN. Mr. Chairman, I have a report made by the Disabled American Veterans on the Livermore, Calif., Hospital, as of April 26, 1945, which I wish to put in at the proper place at the end of Mr. Murphy's testimony. Inadvertently this has not been received. The reporter's report is in and this did not get in the record.

Mr. DOMENGEAUX. Without objection it will be inserted in the proper place in the record.

Mr. DOMENGEAUX. We will recess until 1:30 o'clock p. m.

(Thereupon, at 12:30 p. m., a recess was taken until 1:30 p. m.)

#### AFTERNOON SESSION

The committee reconvened at 1:30 p. m., upon the expiration of the recess.

The CHAIRMAN. The committee will come to order.

Who is the first witness, Mr. McQueen?

Mr. McQUEEN. We wanted Mr. Kidd, on supplies, but he has not yet arrived. However, we can proceed with Mr. Tripp, if that is the wish of the committee.

The CHAIRMAN. Very well. Proceed.

#### TESTIMONY OF LOUIS H. TRIPP, DIRECTOR OF CONSTRUCTION SERVICE, VETERANS' ADMINISTRATION

(The witness was duly sworn by the chairman.)

Mr. McQUEEN. State your full name.

Mr. TRIPP. Louis H. Tripp.

Mr. McQUEEN. And your official position?

Mr. TRIPP. Director of the Construction Service.

Mr. McQUEEN. How long have you been with the Veterans' Administration?

Mr. TRIPP. Since March of 1923.

Mr. McQUEEN. And in your present capacity how long?

Mr. TRIPP. Since July 1 of 1923.



Mr. McQUEEN. Colonel, I presume you have a prepared statement as to the construction program at this time?

Mr. TRIPP. Yes, sir; but if it is agreeable with the chairman, I would like to preface the reading of that with a few remarks and then proceed with the reading of the prepared statement.

The CHAIRMAN. How long is it?

Mr. TRIPP. It is about 12 pages, double spaced.

The CHAIRMAN. Go ahead. If you have any material that you would like to insert in the record you may do so.

Mr. TRIPP. Thank you, sir.

I think it is due to the service that is under my direction, and to the committee, to point out some of the conditions under which we have had to work. They are comparable, of course, with those that apply to every other service in the Veterans' Administration. I do not want to offer this in the way of an alibi, but as an explanation of some of the delay and confusion that have come about.

The war found us short-handed and without adequate space, until in the past few months we have been unable to do much to remedy the situation. We have suffered a good deal because many of my key men have been called or have volunteered for the military service, and because of the nature of our work—they are professional men; they are not young men, many of them, and they are men who held very important key positions. However, since Pearl Harbor we have completed about \$13,700,000 worth of construction work and we have now under construction \$37,000,000 worth, which is twice as much as we had ever handled prior to the present war. Much of it has been handled without any material increase in force. Our force now has been increased and our production is much higher.

A day or so ago there was criticism of some of the conditions that existed at Livermore, and I would like to comment briefly on some of those matters that relate to confusion and delay in delivery of kitchen equipment, improper equipment, and the reorganization of the kitchen building.

I think the first item that was mentioned was that of a sterilizer which is needed for the new operating room which is now being overhauled. We, frankly, ran into difficulties, and the responsibility for that is between my own office and that of Mr. Kidd and, I think, very largely the contractor who took the order.

On July 7, 1944, I approved a requisition for that sterilizer. It was sent to the Supply Service and bids were received, and on August 28 I returned the file recommending acceptance. I think that that was accepted in due course, but it was not until January 6, 1945, that the contractor advised the Supply Service that he could not furnish that particular type of sterilizer. I do not know the circumstances; but that was a delay that apparently was the fault of the man who took the order for that piece of equipment.

The sterilizer has not yet been delivered, but in the meantime a new surgery has been arranged, and I received a letter under date of June 23 from Colonel Radcliff, who is my representative on the west coast, in which he stated that—

Among other items discussed was the question of the surgery, and I find Colonel Beatty desires to occupy this immediately and without any more ceremony. The installation is complete with the exception of the pressure instrument, the sterilizer mentioned in my previous letter and about which I asked for instructions as to location.

With regard to the conditions that he mentioned in connection with the dishwasher, I find, on checking the record from the fiscal year 1941 until the current fiscal year 1946, that we have had relatively few requisitions for kitchen equipment. All of them have been acted upon promptly. I have the detail of the information here if anyone wishes it. We have had no request for a dishwasher. As Colonel Murphy said, it would be desirable in the case of a piece of equipment like a dishwasher to have it fitted to the space that it is going to occupy permanently; and since that kitchen is to be rearranged, it would be desirable to have the new equipment fit the new kitchen. But I want to make it entirely clear that under no circumstances did we permit and would not knowingly permit an item of equipment to remain in the service if it was not capable of washing and sterilizing the dishes as it is supposed to be. To the best of my knowledge, we had never been informed of that situation until this investigation.

Regarding the addition to the kitchen and dining hall building, that matter has been under discussion for a year and a half. There has been a definite difference of opinion as to whether or not a major addition would be required. I would like to point out, however, that this hospital was completed and opened on the 11th of April 1925, with a capacity of 306 beds. The kitchen was enlarged once in 1926, and since then has furnished the service required so far as our records indicate. The subsistence supervisor is at Livermore at present, my representative will be there, and plans and arrangements will be worked out which will provide for satisfactory operation.

From the figures that were quoted here the other day the patient load there at present is no greater than the place was designed for originally, or very little greater than the capacity of the hospital now, 462 beds as compared with an initial capacity of 306 beds.

Mr. SCRIVNER. That is an increase of about 50 percent over the initial capacity.

Mr. TRIPP. Yes; but as I said just now, the number of patients at present there is fairly comparable with the initial capacity for which the place was designed.

The CHAIRMAN. You said you had a written statement. Is that the written statement you referred to?

Mr. TRIPP. No, sir. I thought I would like to make some comment on these items, since they were discussed.

The CHAIRMAN. You may proceed.

Mr. SCRIVNER. I would like to inquire at this point, Mr. Chairman.

The CHAIRMAN. Go ahead.

Mr. SCRIVNER. My recollection is that there had been complaints about that dishwasher for not just a few months, but for a long period of time.

Mr. TRIPP. I have never been able to find those complaints. I have here with me a certified report that was made in 1944 by a representative of my service. We try to make inspections once a year. We do not do it always; but this inspection was made in 1944. The man who made the inspection made no comment on the dishwasher. Under "Kitchen equipment" he stated [reading]:

All inspected and adequate for present load. All considered safe and equipped with pressure gages, relief valves, etc. The outside grease trap is cleaned approximately once each week. Grease through the trap is not sold but is dumped

over the hill. Fire extinguishers of CO-2 type are properly located and serviceable.

He states that the diet kitchen and equipment were inspected.

Mr. SCRIVNER. In that report there is no mention made about the oven?

Mr. TRIPP. About the dishwasher.

Mr. SCRIVNER. You said "all equipment." There is complaint about the oven.

Mr. TRIPP. He stated that he inspected all of the equipment and found it—

adequate for present load. All considered safe and equipped with pressure gauges, relief valves, etc.

When this inspector makes his report and has it prepared he leaves a copy with the manager; and I have the manager's comment in response to that [reading]:

It is agreed that certain changes will be required in the kitchen department and dining hall to properly handle the patient load when alterations of hospital unit are completed.

With reference to the ice-cream-making equipment he says:

The equipment mentioned in this paragraph is nearing its life of usefulness.

Mr. SCRIVNER. What did your inspector say on that?

Mr. TRIPP. That the ice-cream-making equipment, including the compressor, freezing tank, and mixer, are old and obsolete and parts and repairs are often impossible to obtain. It is felt that a complete new unit should be purchased and installed just as early as such equipment may be obtained without hindrance to the war effort.

Mr. SCRIVNER. What did your office do on that recommendation?

Mr. TRIPP. We wrote to the manager on July 3, 1944, and told him to submit a requisition for new equipment. We received his requisition for this new equipment on May 14, 1945.

Mr. SCRIVNER. You told him on July 3, 1944, to get in his requisition, and you received it when?

Mr. TRIPP. On May 14, 1945.

Mr. SCRIVNER. That was about 11 months afterward?

Mr. TRIPP. What correspondence may have gone on in that connection I do not know, but that was when we received the requisition. It has been approved and forwarded to the Supply Service for handling.

Mr. SCRIVNER. If I understood you correctly, you said that for a year and a half you have been discussing the matter of the kitchen and dining room changes out there?

Mr. TRIPP. Yes, sir; of enlarging the kitchen and dining room.

Mr. SCRIVNER. Is there anyone, either you or someone else under you, that can make a decision without talking about it for a year and a half?

Mr. TRIPP. We did not agree with the thought that a material enlargement was needed. My subsistence supervisor did not agree with that. We sent out plans to him and he looked them over. As I pointed out to begin with, this enlargement apparently looked toward a prospective increase rather than the existing situation, and we still have another hundred beds to add at this facility.



Mr. SCRIVNER. Could not the discussion have been quickly ended by a decision in your office stating that "Under the present situation there is no use discussing it any further"?

Mr. TRIPP. We do not like to make an arbitrary decision of that sort if we can avoid it. We like to come to an agreement.

Mr. SCRIVNER. I noticed that in the length of time it took to make a decision on the Kansas City Hospital site. If the delay encountered there is typical of the delay encountered at other places, I am not surprised that the building program is behind. It was something like 14 months before a decision was made.

Mr. TRIPP. I do not have any comment to make on that. I do not agree that the building program is behind.

Mr. SCRIVNER. Indications are that they are short of space. When you have got an overload, as has been testified to so many times, there is only one thing you can do, and that is either increase the capacity or else cut down the load. But you have nothing to do with cutting down the load or increasing capacity. Your duty is confined primarily to the physical building?

Mr. TRIPP. Yes, sir; what is approved.

Mr. SCRIVNER. That is all I have at present.

Mr. DOMENGEAUX (presiding). You have a statement to present?

Mr. TRIPP. Yes, sir.

Mr. DOMENGEAUX. May I ask you this question, sir. Is the situation improving as to the ability of the Administration to secure priorities to get the necessary materials and equipment to bring about these improvements as fast as is desirable?

Mr. TRIPP. We are not having many delays based on priorities. Of course priorities are being eliminated to a large extent. We apprehend some difficulty in securing materials when the emergency is removed, because while the War Department and the Navy Department still retain their control our orders cannot be placed until we have authority and have an authorized project to place them for; and we are rather fearful that we may be in the position of coming in at the tail end of a manufacturer's capacity where he may have various civilian orders that he is committed to. We have been trying to get the War Production Board to straighten that angle of it out. Actually at present I believe we are not being delayed materially on account of priorities; but as soon as we got out of that trouble we got into the manpower trouble.

Mr. DOMENGEAUX. Then it becomes a competitive proposition?

Mr. TRIPP. Yes.

Mr. ENGLE. I am sorry that I was late in arriving. Did you give testimony about the dishwasher at Livermore?

Mr. TRIPP. Yes. I stated before you came in, Mr. Engle, that we learned that what Colonel Murphy said is true, that it would be desirable to get a piece of equipment that was going to fit in to the new arrangement that we are developing now, and we certainly would not permit the use of a piece of equipment that is incapable of performing the work that it is supposed to do, if it is the fault of the equipment. That is the first thing we find out, as to whether or not the dirty or unsterilized dishes are the fault of the equipment or of the operation.

Mr. ENGLE. You had an officer out checking Livermore, did you not?

Mr. TRIPP. We have a check made every year.

Mr. ENGLE. But was not someone specially sent out from the central office here?

Mr. TRIPP. There is a subsistence supervisor there now, and he will be asked to look into that feature immediately.

Mr. ENGLE. I got the impression that someone went out from here.

Mr. MATHES. That is the Pacific coast representative of the Administrator. He is located on the Pacific coast all the time, the man to whom we refer.

Mr. ENGLE. What is his name?

Mr. MATHES. Shields. He is the man that wrote in here and we reported to the committee on his report.

Mr. ENGLE. His report is in the record?

Mr. MATHES. Not his report, but a letter from General Hines stating the substance of the part of the report relating to this question. You see, Mr. Shields was out there for various purposes, and his letter to the committee is in the record.

Mr. McQUEEN. My recollection is that that portion of the letter is in the record. It was asked for one day and brought in the next morning.

Mr. MATHES. I do not know what day it was, but I brought it over here, and I think it went into the record.

Mr. DOMENGEAUX. You may proceed with your statement, Colonel Tripp.

Mr. TRIPP. I will begin my statement with a brief recapitulation of certain action by the Federal Board of Hospitalization prior to the date of Pearl Harbor.

On July 29, 1937, the Board recommended to the President that a prescribed policy regarding future construction of hospital facilities for veterans be approved and followed. Briefly, this policy included the provision of sufficient beds to take care of all neuropsychiatric and tuberculous cases requiring hospitalization, who meet the eligibility requirements. With reference to general medical and surgical cases, it stated that no general construction program for this group should be undertaken unless it was found that the veterans in a given area did not have a proportionate number of beds equal to the average number of beds provided in other given areas. This resolution was approved by the President on September 30, 1937.

By memorandum of April 18, 1940, the Board recommended to the President a specific construction program in pursuance of the approved policy, and for accomplishment from year to year within a 10-year period. This was approved in principle by the President on May 8, 1940, with the understanding that the proposed program would be reviewed, annually, and with certain other instructions which are being complied with.

By resolution of July 16, 1940, the Board recommended to the President that in case of immediate expansion of the Army and Navy, the Veterans' Administration should relinquish, insofar as possible, beds occupied by veterans in Army and Navy hospitals; and that in the event of a major national emergency the general facilities of the Veterans' Administration be utilized by members of the armed forces who are injured or incur disabilities in service and whose physical rehabilitation by the Army and Navy is not feasible. The President

approved this resolution on September 17, 1940. After the expansion of the Army and Navy had begun and prior to December 7, 1941, 2,022 members of the armed forces were admitted to Veterans' Administration facilities for treatment. Between December 7, 1941, and April 1, 1945, 155,953 veterans of World War II have been admitted to our hospitals, and 18,912 of these veterans remained in our hospitals on the latter date.

By resolution of March 9, 1942, the Federal Board of Hospitalization recommended to the President that he authorize the accomplishment at an accelerated rate of the remaining projects in the 10-year construction program. The President on April 2, 1942, approved this resolution for the consideration of estimates, but without commitment as to amounts or projects to be approved.

During the 2 years prior to the beginning of the war very little new construction work was undertaken by the Veterans' Administration. It was felt that nothing should be done to interfere with the mobilization effort, and even during this period many materials essential for construction were in short supply.

During the fiscal year 1940 only four bed-producing projects were placed under contract; these included 296 additional hospital beds and 392 additional domiciliary beds.

During the fiscal year 1941 three projects producing a total of 397 hospital beds were placed under contract.

During the fiscal year 1942 three projects providing a total of 639 additional hospital beds were placed under contract. During this fiscal year two projects had to be withdrawn from the market due to limitations on essential materials. In that case the War Production Board would not give us a clearance on materials. In the case of one other project no bids were received. Bids for two other projects, neither of which would have provided additional beds, were rejected because only one bid in each case was received, that being excessive.

During the fiscal year 1943 four projects were placed under contract providing for a total of 761 additional hospital beds.

During the fiscal year 1944 17 projects were placed under contract providing for a total of 5,939 additional hospital beds.

During the fiscal year 1945 17 projects have been placed under contract to date providing a total of 6,710 additional hospital beds.

Prior to the passage of the Servicemen's Readjustment Act of 1944, which was approved on June 22, 1944, a great deal of difficulty was experienced in securing priorities and allocations adequate to insure the timely delivery of materials to the job. This situation resulted in considerable delay in the completion of work after it had been placed under contract, as well as considerable delay in having the project processed by the War Production Board to the point where it could be placed under contract. The matter of priorities was the subject of many conferences and a large volume of correspondence with the War Production Board. Since passage of the Servicemen's Readjustment Act of 1944, delays due to inadequate priorities and allocations very largely have been eliminated. However, during this past year there have been material delays in actual construction because of the shortage of available manpower, particularly common labor; and to a considerable extent because of the unusual severity of the past winter in certain sections of the country.



During the summer of 1942 the rate at which neuropsychiatric veterans were being admitted to our hospitals made it evident that some emergency measures would have to be undertaken in order to provide for these cases pending the completion of new construction. Our bed capacity standards, while not extravagant, are reasonably liberal, and up to that time had always been strictly adhered to, no attempt having been made to take care of patients beyond the rated capacities of the hospitals. At that time it appeared that this strict adherence to standards would have to be departed from as a temporary emergency measure and to such extent as might be practicable without interference with the administration of proper treatment. Plans of our existing hospitals were studied and inspections were made at some of the sites and in collaboration with the local managers. It was found that some worth-while increases could be secured in this way. In general the methods by which these increased emergency capacities have been secured are as follows.

1. By reducing the bed spacing in chronic infirm, acute, and medical and surgical wards, from a minimum of 5 feet 6 inches to a minimum of 5 feet—that bed spacing is not the space between the beds, but the space between the bed centers—which latter distance has for many years been our standard for parole and continued-treatment patients.

2. By moving ward dining rooms and serving kitchens, which are provided in certain types of buildings, from the first floor to basement space, and using the dining room and kitchen area for beds.

3. By converting approximately 50 percent of the day room area, in parole and continued-treatment buildings, to bed space. (This procedure has been necessary in only a few cases.)

4. By the establishment of central clothing rooms in basements, and the utilization of ward clothing rooms for additional beds.

In most cases a combination of the methods mentioned has been used except that, as noted, a reduction of the day room space has been resorted to in relative few cases.

Authority was given about April 10, 1943, to each of our neuropsychiatric hospitals to set up overcapacity beds to the extent of 10 percent of the total capacity of the hospital, following the general methods outlined. Subsequently, and on the request and recommendation of various managers, further increases in overcapacity beds have been authorized. Out of a total of 40,101 beds, based on standard capacity, a total of 6,338 overcapacity emergency beds have been authorized, making a grand total of 46,439 beds, of which 42,651 were in use on March 31, 1945.

In the case of general medical and surgical hospitals similar methods of establishing temporary overcapacity beds have been authorized at 31 of our 51 stations caring for patients of this type. At these stations having a total standard capacity of 19,418 beds, a total of 3,468 emergency beds have been authorized, making a grand total of 22,886 beds, of which 16,111 were in use on March 31, 1945.

It is, of course, intended to discontinue the utilization of these overcapacity beds as quickly as the provision of additional standard capacity beds can be accomplished through new construction.

The effectiveness of this method of providing, temporarily, for additional beds is not uniformly effective since in our hospitals certain

buildings and certain wards are designed for certain types of patients. Thus, in a neuropsychiatric hospital the demand for beds to care for patients who are acutely disturbed cannot be satisfied by the establishment of overcapacity beds in buildings that are designed for the care of continued treatment or parole cases. Also, the fact that a shortage of nurses and attendants has existed makes difficult the administration of wards and buildings carrying more than the capacity for which they were designed. In fact, in many cases where crowding has been complained of, it has come about through a shortage of personnel, which has forced local managers to discontinue the operation of some wards and to operate other wards at overcapacity.

In August of 1942 a program was developed providing for the erection of approximately 800 additional beds for neuropsychiatric patients. This recommendation was favorably acted upon by the Federal Board of Hospitalization on October 28, 1942, and approved by the President on December 31, 1942.

Projects for which approval was obtained had not been provided for in any of our appropriation estimates and the funds for this work were obtained through the deferment of certain projects for which funds were available in existing appropriations. The projects that were deferred included several recreation buildings, a shops building, a library building, a domiciliary building, and several other similar projects. We were unable at that time to obtain priority ratings that would permit of the construction of projects that did not provide for additional beds. In addition to the 800 beds obtained through this transfer of funds, we also secured approval in 1942 for the erection of an additional building for neuropsychiatric patients at Canandaigua, N. Y., for which funds had been provided in our 1942 fiscal year estimates, and in 1943 we secured approval for the erection of additional neuropsychiatric buildings at Knoxville, Iowa, and Lexington, Ky., funds for the latter two projects being provided in our 1944 fiscal year estimates. During 1943 we also started construction of a new clinical building at Marion, Ind., which provided additional beds for neuropsychiatric patients. These projects provided a total of 1,336 additional beds for patients of this type.

I would like to interject at this point that we are deficient in recreational buildings, in recreational facilities, and in occupational therapy space at many of our hospitals. Up to this time we were not permitted to build anything of the sort. Until this war occupational therapy was not a very active thing at any of our general or tuberculosis hospitals; in fact, I do not think many of them provided for it. With the younger men coming in we have got to have it at all of them, and we are behind and we have got to do a lot of work on it.

Mr. DOMENGEAUX. Will the deficiencies that you mention be eliminated and taken care of under the building program that has recently been announced?

Mr. TRIPP. Yes, sir; just as rapidly as we are able to do it.

Mr. DOMENGEAUX. How far has that progressed?

Mr. TRIPP. The program that has just recently been announced?

Mr. DOMENGEAUX. Yes.

Mr. TRIPP. That of course is not yet an authorized program.

Mr. DOMENGEAUX. What is its present status?

Mr. TRIPP. It is before the Federal Board of Hospitalization.

Mr. DOMENGEAUX. Recommendations have been made to the Federal Board?

Mr. TRIPP. Yes, sir.

Mrs. ROGERS. Does not the Federal Board of Hospitalization always carry out your recommendations?

Mr. TRIPP. I would say, Mrs. Rogers, that they usually do. I do not think I would say that they always do.

Mrs. ROGERS. You are very short in certain hospital areas of quarters for nurses, are you not, such as at West Roxbury?

Mr. TRIPP. Yes. Personnel quarters all over the country are a tremendous problem.

Mrs. ROGERS. They have to leave at 4:30 in the afternoon in order to get home.

Mr. DOMENGEAUX. Do you have any idea when the Federal Board is going to take action on that matter?

Mr. TRIPP. No, sir. They are meeting on Monday. I hope they will act on it at that time.

Mrs. ROGERS. Are you using Army engineers? I made that recommendation to General Hines quite a long time ago, and I understand that very recently he finally adopted it.

Mr. TRIPP. They are and have been for some time assisting us.

Mrs. ROGERS. I know that your office has been very much overworked in connection with it.

Mr. TRIPP. I would like to amplify my reply to the chairman just briefly on these hospitals that are in our currently authorized program and those that are in the program that has been recommended—that we shall endeavor in the new hospitals to provide reasonably adequate recreation space and occupational therapy space, and so on, that will be beyond any scale that we have previously undertaken. In the same way we will undertake to correct deficiencies at the hospitals where we are going to provide additions. Our first requirement must be more hospital beds. At those places where we are going to build we shall certainly try to correct all of those deficiencies.

Mrs. ROGERS. In how many places are you over a year behind in building, such as building hospitals for women patients with nervous cases, such as at Bedford?

Mr. TRIPP. You mean the one at Bedford?

Mrs. ROGERS. In how many similar places are you over a year behind on that?

Mr. TRIPP. I do not know that I am quite clear as to what you are referring to when you speak of being a year behind.

Mrs. ROGERS. General Hines told me that the hospital would be ready a year earlier than it will be, and I wondered how many other hospitals are in the same status—a year behind in completion.

Mr. TRIPP. I am not familiar with that. Of course, as you know, we have not had the force. We never have been able to make our plans much, if any, in advance of the appropriation. With a program of any size, we have never been able to put it on the market at one time and get it under contract at one time.

Mrs. ROGERS. The Appropriations Committee has never refused you any appropriation that you have asked for.

Mr. TRIPP. My force has been kept at the level of what we needed to do what work was before us. We have never had much opportunity



to plan in advance and have plans ready for a program that had not yet been authorized, and, of course, when those programs are authorized we cannot do all of those jobs at one time.

Mrs. ROGERS. Colonel Tripp, why has not the Administration built porches on hospitals, such as they have at Walter Reed Hospital?

Mr. TRIPP. For the reason that our medical service does not like porches.

Mrs. ROGERS. Do you know why?

Mr. TRIPP. No.

Mr. DOMENGEAUX. They are using these porches now, are they not?

Mrs. ROGERS. Take all the spinal-cord cases: Those boys would like to be moved out and get the sunshine and the air. It would do them incalculable good.

Mr. TRIPP. It is my impression—you would have to ask the medical service directly—that they feel that they would rather have a sick man in bed than moving around a porch—in the case of tuberculosis.

Mrs. ROGERS. But there are many cases that are not tuberculosis cases.

Mr. TRIPP. I think the same thing applies generally.

Mr. SCRIVNER. Colonel, if I understand you correctly, even though this hospital board, after apparently some delay, will meet on July 2 to discuss many of these things, as yet you do not have any plans on paper even for those things that will be approved?

Mr. TRIPP. We have some preliminary plans, but we have no finished plans for them.

Mr. SCRIVNER. Apparently that has been true all the way through. In other words, you have no blueprints so that as soon as an appropriation is made you can step right in and start to work?

Mr. TRIPP. That is correct.

Mr. SCRIVNER. In other words, you have some idea of what you want to do, and it is submitted, and finally the hospital board acts upon it. In many cases I think they have delayed quite a while on some of their recommendations, have they not?

Mr. TRIPP. I have a few reports here, but I think that generally action by the Federal board has been rather prompt.

Mr. SCRIVNER. Then, finally, there is an appropriation, and when it is made you sit down and start drawing your blueprints?

Mr. TRIPP. I do not want to make that impression too severe, Mr. Scrivner. We do a great deal of advance study. For instance, if we are going to build an addition at Rutland, as we are we undertake the sketching of that often times a year or so in advance. We have never been able to work out and finish up working drawings and specifications ready to go on the market. After approved sketches have been developed it takes 60 or 90 days.

Mr. SCRIVNER. It takes quite a while to make the finished drawings?

Mr. TRIPP. Yes; and when we have a big program of some \$80,000,000 before us we cannot do it all at once. We are going to employ private architects to whatever extent will help us to accelerate the rate of production, and we will handle it at a higher rate of production than we have in the past.

Mr. SCRIVNER. Have you ever at any time come before this committee or had General Hines come before this committee and suggest that you should be given a larger force so that you might anticipate

and make some of those plans ahead, so that as soon as plans are accepted and an appropriation is made you could immediately go to work on the project?

Mr. TRIPP. So far as I know, that has never been presented to the committee.

Mr. SCRIVNER. Had you or the group under you, when the rumblings of war seemed to be approaching the horizon, made any tentative plans of what your group was going to do? Had you made any study of veteran population areas or anticipated plans as to where the added facility space must be located?

Mr. TRIPP. We spent a great deal of time on that sort of thing.

Mr. SCRIVNER. After having discussed those plans, had you gone any further than that? Did you look ahead?

Mr. TRIPP. We tried to.

Mr. SCRIVNER. And plan ahead, so that if certain situations developed they could be taken care of? Certainly it could be anticipated after Pearl Harbor, when the Army and Navy were being enlarged, that in a certain place the veteran population was going to be increased, and therefore at that place you were going to need a hospital or an addition to one. Were those plans made?

Mr. TRIPP. No plans along that line were ever made. We studied that sort of thing a good deal, but we never went ahead with any of it.

Mr. SCRIVNER. In other words, there was not a great deal of vision exercised, then?

Mr. TRIPP. Well, perhaps not. I wanted at various times to go ahead and do just that.

Mr. SCRIVNER. Upon whom did you urge that?

Mr. DOMENGEAUX. What is that question?

Mr. SCRIVNER. He said that many times he wanted to go ahead and develop some of these plans. I was just wondering to whom he had made that suggestion, because as matters now stand it puts the colonel in a rather unfavorable light. That is why I asked the question.

With whom did you discuss your desire to plan ahead?

Mr. TRIPP. I discussed it with Colonel Ijams and the Administrator at various times. I have here a memorandum that I addressed on the 26th of January to Colonel Ijams.

Mr. SCRIVNER. What action was taken on that?

Mr. TRIPP. It was never acted on, so far as I recall. I will have to look at the concluding paragraph. If you wish me to read it, I will read it.

Mr. SCRIVNER. No; I just want the general gist of it.

Mr. TRIPP. I think I had better read one or two paragraphs in the middle of it [reading]:

At present and the next 6 to 12 months will probably represent the most unfavorable time to undertake large additional construction, both from the standpoint of the Veterans' Administration and from that of the general war effort. Any decision to undertake construction of large additions to our facilities in a short time would probably involve the adoption of frame construction, fee basis contracts, and the extraordinarily high costs which prevail at this time. A decision to build at this time but without attempting very rapid construction, would involve a choice between our present standards of design modified as may be necessary and a simplified design in fireproof construction. High costs would be involved in either case, although the work could probably be done by lump-sum contract under competitive bids, and the time for completion would be uncertain.

It was also stated:

Any construction work undertaken at this time would be in direct competition with the war effort. On the other hand, work undertaken after the peak of war construction has passed will help to stabilize the industry.

My view of the time during which the War Department would be building was entirely overoptimistic, but it was my judgment as a suggestion. In concluding this memorandum, I said:

In conclusion I would like to again emphasize the need for an early start on plans. There is no question in my mind that we would be better off financially if we planned \$20,000,000 worth of construction and then only built \$5,000,000 worth of it than if we wait until the emergency is on us and then have to plan \$5,000,000 worth of construction under rush conditions. Taking cognizance of the trend of the present situation and taking prudent steps toward meeting it at the proper time would also furnish an answer to various criticisms, suggestions, and inquiries which we are receiving from time to time.

Mr. SCRIVNER. The date of that was what?

Mr. TRIPP. January 26, 1942.

Mr. SCRIVNER. As I understood your statement a few moments ago, you have no response to that suggestion, or no action was taken upon it?

Mr. TRIPP. Colonel Ijams sent a memorandum on February 4 to the Administrator.

Mr. SCRIVNER. 1942?

Mr. TRIPP. Yes. He recommended acceleration of those projects contained in the 10-year construction program, for 12,000 additional beds.

Mr. SCRIVNER. But you do not know what response Colonel Ijams got to that from the Administrator?

Mr. TRIPP. I do not have it in mind.

Mr. SCRIVNER. That would have to come from Colonel Ijams. Of course, you understand the import of my question, namely, that there has been a lot of criticism of lack of vision, and foresight, and planning on the part of the Administration; and part of the purpose of this investigation is to find out where the fault, if any, is.

Mr. TRIPP. I took cognizance of that in this memorandum.

Mr. SCRIVNER. Far be it from me to place any blame on any person who is not primarily responsible for it. Frankly, I understand the position that you and others who work with you occupy.

Mrs. ROGERS. I would like to ask a question. So far as the care of the NP cases is concerned, the Army hospitals are not equipped to take care of them for any great length of time, are they?

Mr. TRIPP. Not in my opinion. I have never visited any of the new Army hospitals, but I have seen the plans. They are not suited for that type. I think the Army authorities would tell you the same thing.

Mrs. ROGERS. I know, Colonel Tripp, that you were very anxious to have plans made, because I asked you repeatedly if plans could not be made for the building of hospitals for the veterans. I felt that the public wanted those hospitals just as much as they wanted hospitals for the Army and the Navy, and I realized of course that you would do what you were asked to.

Mr. TRIPP. The Army and Navy, during the preparation of defense and during the war, of course, have to take precedence over anything else.



Mrs. ROGERS. There was a great deal of civilian building, such as apartment building, going on.

Mr. TRIPP. Until the passage of the Servicemen's Readjustment Act we were no better than any civilian agency. We came under the same department in the War Production Board that every county or State hospital did. What we got out of them we got by arguing and fighting with them from daylight until dark, and we had to do a great deal of it. We did get some special consideration, but it was difficult.

Mrs. ROGERS. The Army engineers told me they were available at quite an early date after Pearl Harbor.

Have you had many changes of hospital sites? For instance, the Administrator authorizes the building of a hospital in one spot, in one part of a State, and then changes it to another State or to another place in the same State?

Mr. TRIPP. Not that I can recall.

Mr. SCRIVNER. In other words, although it may take a long time to make up your mind, once it is made up it is not changed.

I wonder if I may ask one more question. In how many instances did it take as much as a year or 14 months to finally determine the sites of hospitals?

Mr. TRIPPE. I cannot answer that offhand, Mr. Scrivner. I would say, very, very few cases. I think the case you have in mind—perhaps for some reason with which I am not familiar those site inspections were undertaken a little prematurely.

Mr. SCRIVNER. I would not ask you to express yourself. I have my views on the reasons.

Mr. DOMENGEAUX. If the present program is carried on in the most expeditious manner, can you estimate how long it will take to complete the program?

Mr. TRIPP. You mean, the one that is now under discussion?

Mr. DOMENGEAUX. The one that is under discussion and has just been recommended to the Hospital Board.

Mr. TRIPP. I believe I would like to ask Colonel Ijams to confirm this. I believe that is planned for completion within 3 years from now. [After conference.] We at first thought it might be completed in 2½ years, but it has been planned now to build it in 3 years from now.

Mr. DOMENGEAUX. How are we going to take care of these boys in the interval? Your present facilities are just about at the maximum capacity at this time. How are you going to take care of these poor boys who are coming in monthly, and whose numbers will be greatly increased in the months to come?

Mr. TRIPP. I think that the biggest load is going to be on the neuro-psychiatric side. I will come to that a little later in my statement, if you wish me to finish it. We do have a good many of the general medical and surgical type, NP and TB cases, coming in. All of them are based on our best judgment, based on the experience of the other war and the experience in this war to date as to what we shall need at those times.

Mr. SCRIVNER. If I may interpose there, we are going to have to get down to some realistic thinking; and while it may be a tremendously unpopular thing to do, eventually someone is going to have to make a decision to the effect that in order to take care of the load upon the doctors, nurses, and attendants, there is going to have to be

a sharp curtailment of treatment and care of non-service-connected cases. I think the figures showed earlier in the hearing that 60 percent of those in the hospitals now were non-service-connected cases. We have got to take care of service-connected cases, no matter what else is done. If we cannot get hospitals built fast enough, cannot enlarge the staffs fast enough, cannot get attendants to take care of the patients, there is only one solution, and that is that you have got to decrease your load, and the only way you can justify any action like that would be in the reduction of non-service-connected cases.

Mr. DOMENGEAUX. Under the present law, is not that the fact now?

Mr. SCRIVNER. That is optional with the Administrator. He only has to accept those non-service-connected cases where he has staffs and facilities available. We have seen the picture here of every facility in the country where the capacity has been increased; that is, the bed capacity has been increased by using space not originally designed for such purpose, and the installation of what they call emergency beds, which is an added load upon the staff. When I say staff, I mean doctors, nurses, and attendants. It is really an extra heavy load. So, as I would view it now, by reason of the difficulty we are having, those emergency beds are in excess of the capacity of the hospital, and about the only thing we can do is to discharge the non-service-connected cases to bring the load down to where the staff can handle them properly. Somebody is just going to have to take the bull by the horns and say, "We can't take any more non-service-connected cases until this load is cut down where we can handle it." And that, too, does not include non-service-connected mental or TB cases. We are going to have to carry them. Everybody realizes the necessity and the propriety of doing that.

Mrs. ROGERS. As to TB cases, have we not passed legislation that would service-connect them presumptively?

Mr. SCRIVNER. Whether they are service-connected or not, as far as TB and NP cases are concerned, there is a public burden there.

Mr. TRIPP. May I add a word to your thought, Mr. Scrivner? I would assume that with the application of these overcapacity beds, where we have patients in rooms that were not designed for patients originally, and where the wards in which the patients are located are taking care of 10 percent more patients than they were designed for, that probably the ratio of nurses and attendants would be greater under those conditions than under normal conditions. But just the reverse of that situation exists.

Mr. SCRIVNER. Each doctor and each nurse and each attendant has more men to take care of than was anticipated and recognized as good practice. We cannot get more doctors; we know that. It is almost impossible to get any more nurses. You had 80 percent turn-over in attendants. So, when you just cannot get an increased staff, you have got to cut down the load and see that those that do remain in the hospitals get the care and treatment that they desire.

Mr. CARNAHAN. Are we going to accept the philosophy that we have a problem that we cannot solve?

Mr. SCRIVNER. No matter what legislation we pass here it is not going to give us any more doctors, nurses, or attendants right now.

Mr. DOMENGEAUX. It is a temporary situation.



Mr. SCRIVNER. Surely; but it is a situation for which we do not have a solution right now.

Mrs. ROGERS. There is one way that we might reduce the patient load for the doctors and nurses, and that is by sending them to regular hospital clinics. That is being done in Boston. For the time being they take some of those cases and thereby relieve the doctors from the hospital load and relieve the nurses also.

Mr. TRIPP. In connection with these first buildings to be erected for the care of neuropsychiatric patients many alternatives were suggested by the War Production Board and discussed at length with representatives of that agency. The application which included these projects was submitted on October 30, 1942. On November 27 various suggestions were made by the War Production Board, including the use of beds in spas throughout the country for the purpose of housing neuropsychiatric patients. It was pointed out that on account of the general construction and arrangement of such institutions this Administration did not consider the suggestion practicable, particularly in view of the need for providing adequate protective and detention features and treatment facilities in buildings which are to be used for the care of neuropsychiatric patients. At the further suggestion of the War Production Board this question was submitted to a medical authority suggested by them. The opinion received in reply to this inquiry was in general conformity with the opinion of the Veterans' Administration. The War Production Board issued priority ratings for the various individual projects included in this program to provide additional neuropsychiatric beds between March and August, 1943.

Following the passage of Public, No. 10, Seventy-eighth Congress, on March 17, 1943, an act which authorized the hospitalization of non-service-connected World War II cases, a recommendation was submitted to the Federal Board of Hospitalization, providing for the acquisition of 4,278 additional beds for neuropsychiatric patients through additions at existing hospitals. The Federal Board of Hospitalization considered this proposal on March 25, 1943, and recommended adoption of the program submitted. This resolution of the Federal Board of Hospitalization was transmitted to the Bureau of the Budget on March 30, 1943, and returned to the Board by the Bureau of the Budget on April 20, 1943, for "more comprehensive development in planning for post-war hospitalization."

On April 29, 1943, the Technical Advisory Committee of the Federal Board of Hospitalization reviewed this program and on May 17, 1943, the resolution was returned to the Bureau of the Budget. The President approved the program on June 11, 1943. As funds for the accomplishment of these projects were not available in the then existing appropriations, a request for a deficiency appropriation was sent to the Bureau of the Budget on June 24, 1943.

In order to start some of the projects prior to action by the Congress on the deficiency appropriation, the President's approval was requested for a temporary deferment of certain projects in our construction program for which funds were then available and the utilization of these funds for some of the additional neuropsychiatric bed projects. The President approved this reallocation on July 26, 1943. The de-



iciency appropriation covering this program was approved on December 23, 1943 (Public No. 216, 78th Cong.). Work included in this program was placed under contract prior to May of 1944. Construction to provide 1,646 beds has been completed, and the balance will be completed within the next three months.

On September 16, 1943 an additional construction program was submitted to the Federal Board of Hospitalization. This contemplated additional construction to provide 9,052 beds for neuropsychiatric patients and included the establishment of two new hospitals together with construction for additional beds at 16 existing hospitals. This program was recommended for approval by the Federal Board of Hospitalization on September 24, 1943 and was submitted to the Bureau of the Budget on October 7, 1943. On November 23, 1943, it was returned for further information including additional supporting material. This was furnished to the Director of the Budget on December 23, 1943 and the President approved the program on January 13, 1944. Funds for the accomplishment of this program were included in Public No. 279, Seventy-eighth Congress, which was approved on April 1, 1944. With the exception of one of the new hospitals all the work covered by this program is now under contract.

With regard to provisions for female beneficiaries it is planned to provide an appropriate number of beds at each new general medical and surgical and tuberculosis hospital, and to provide for an adequate number of beds through reallocation of space at all of our existing hospitals of these types as the need develops.

We have available for psychotic women patients a total of 442 beds at 7 facilities. There are under contract a total of 654 beds for patients of this type at 11 facilities, and future plans will provide for a further increase of beds of this type and for a further distribution at new or existing facilities.

We now have 184 beds for domiciliary women at three facilities, and our current recommendations provide for the establishment of additional facilities of this type by the enlargement of existing facilities and the establishment of new facilities where no provision has been made as yet; this will provide for a total increase of 539 beds.

The CHAIRMAN. Have you completed your statement?

Mr. TRIPP. I would like to summarize briefly, Mr. Chairman, as follows:

On November 30, 1941, the Veterans' Administration was operating 91 facilities. The number of beds available and the number of patients of each type in veterans' hospitals and members present in domiciliary barracks were as follows:

Type	Beds available	Patients
General medical and surgical	20,750	16,813
Tuberculosis	5,193	4,653
Neuropsychiatric	35,902	33,914
Total, hospital	61,845	55,380
Domiciliary	18,725	15,809

At the present time (March 31, 1945) 95 facilities are in operation and figures as to capacity and occupancy are as follows:

Type	Beds available		Patients
	Stated capacity	Over capacity	
General medical and surgical	1 19,418	3,468	16,111
Tuberculosis	7,889	9	6,348
Neuropsychiatric	40,101	6,338	42,651
Total, hospital	67,408	9,815	69,569
Domiciliary	2 12,910	437	9,448

<sup>1</sup> Decrease in general medical and surgical beds available is a result of a greater utilization of beds in tuberculosis hospitals for tuberculous patients.

<sup>2</sup> Decrease in domiciliary beds is a result of the conversion of Waukesha, Wadsworth, and Togus and the use of domiciliary buildings at Los Angeles and Keesauhtan by the Army.

Construction is in progress or under contract to provide additional beds at existing facilities and at two new facilities as follows:

Type:	Capacity
General medical and surgical	950
Tuberculosis	354
Neuropsychiatric	12,221
Total	13,525

Of the additional construction which has been authorized prior to the Independent Offices Appropriation Act for 1946 which was approved by the President on May 3, 1945, four projects including two new facilities have not yet been placed under contract. These include additional beds as follows:

Type:	Capacity
General medical and surgical	750
Tuberculosis	100
Neuropsychiatric	1,492
Total	2,342

It is anticipated that all of these will be started within the next 90 days.

The Independent Offices Appropriation Act for 1946, previously referred to, provides for additional beds as follows, including 18 new facilities and additions at 12 existing facilities:

Type:	Capacity
General medical and surgical	8,000
Tuberculosis	3,400
Neuropsychiatric	2,700
Total	14,100

The CHAIRMAN. Are there any questions, Mr. Cunningham?

Mr. CUNNINGHAM. No, sir.

The CHAIRMAN. Mr. Scrivner?

Mr. SCRIVNER. No, Mr. Chairman. While you were out I asked a few questions.

The CHAIRMAN. Mr. Carnahan?

Mr. CARNAHAN. Did I understand you to say that the total beds in all facilities were 61,845, all classes of patients?

Mr. TRIPP. That was on November 30, 1941—61,845.

Mr. CARNAHAN. Do you have the total figures as of the present day?

Mr. TRIPP. These figures are as of March 31, 1945, 67,408 plus 9,815 over-capacity beds.

Mr. CARNAHAN. Does that mean emergency beds?

Mr. TRIPP. Yes.

Mr. CARNAHAN. How about your total patient load?

Mr. TRIPP. It is 69,569.

Mr. CARNAHAN. You still have spare beds, do you?

Mr. TRIPP. In the over-capacity beds; yes.

Mr. CARNAHAN. I just want to say that I do not subscribe to the idea that we should not push this attempt to furnish hospitalization for all veterans, regardless of service-connected or non-service-connected, and I rather hesitate to accept the philosophy that we have an assignment that we cannot perform.

Mr. SCRIVNER. My suggestion was merely a temporary matter. You heard the medical officers who were here yesterday tell you that not only was it difficult to get help now, but it was becoming increasingly difficult and would be during the next 5 years. I was accepting their word for it.

Mr. CARNAHAN. Because it happens to be a difficult task is no reason why we should not undertake to solve it.

Mr. SCRIVNER. I agree with you perfectly that we should make every effort. I am raising that question not because I wanted to. Lord knows how unpopular it is going to be throughout the length and breadth of the country, but it is one of the things that we have got to face.

The CHAIRMAN. Back in the 1920's we had a similar discussion. We are going rather far when we now attempt to hospitalize every man for every cause, because he wore a uniform, especially with the limited facilities that we have and with the demand we are going to have in connection with those service-connected cases.

Mr. CARNAHAN. We are taking our manpower and our resources and are devoting them to the building of automobiles and everything else. It is my opinion that enough of that manpower and material should be assigned to provide adequate care for the ex-serviceman, whether his case is service-connected or non-service-connected.

Mr. DOMENGEAUX. You may have answered this question, but can you tell offhand the number of patients that will be taken care of under the new program that is now in contemplation; how many additional beds?

Mr. TRIPP. For the program that is now authorized there are 14,100 beds. In the program we have just recommended there are 26,772 additional beds.

The CHAIRMAN. That includes the 14,000 mentioned?

Mr. TRIPP. No, it does not.

The CHAIRMAN. We thank you very much for your statement.

Mr. TRIPP. I have additional information on hospital beds which will be available.

The CHAIRMAN. Without objection, it may be admitted for the record.



(The matter referred to is as follows:)

It is estimated that during the 12 months ending June 30, 1945, the number of patients in our neuropsychiatric hospitals will increase by 4,550—an average increase of 379 per month. During the same period it is estimated that construction, which is now in progress, will be completed to provide a total of 8,731 additional beds for patients of this type—at an average rate of 728 beds per month.

#### STATEMENT OF RAYMOND C. KIDD

Mr. McQUEEN. State your full name, please.

Mr. KIDD. Raymond C. Kidd.

Mr. McQUEEN. You are with the Veterans' Administration at this time?

Mr. KIDD. Yes, sir.

Mr. McQUEEN. And in what capacity?

Mr. KIDD. I am Director of the Supply Service of the Veterans' Administration.

Mr. McQUEEN. And under whose direct supervision are you?

Mr. KIDD. Colonel Ijams, the Assistant Administrator.

Mr. McQUEEN. How long have you been in that capacity with the Administration?

Mr. KIDD. I have been in my present position since June 1, 1938.

Mr. McQUEEN. And how long with the Veterans' Administration?

Mr. KIDD. Since 1922.

Mr. McQUEEN. Now, Mr. Kidd, have you a prepared statement that you wish to read to the committee?

Mr. KIDD. Yes, sir; I have.

Mr. McQUEEN. May we proceed with the statement, then?

The CHAIRMAN. You may proceed.

Any of it that you care to not read, may be submitted for the record, and we will interrogate you about it when you get through.

Mr. KIDD. Very well.

The CHAIRMAN. Mr. Kidd, has that phase of the Veterans' Administration been attacked in these articles?

Mr. KIDD. No, sir.

The CHAIRMAN. Then, why take up the time of this investigation with it?

Mr. KIDD. Well, sir, I was asked to prepare this statement. The Administrator requested that I prepare the statement. I have, sir, in here, some data that I think would be of interest in the way of advance planning.

Mr. McQUEEN. Well, Mr. Chairman, may I say that if not directly certainly indirectly that department has been charged with not furnishing the supplies to hospitals at some points at least, and even down to food, and that is the reason I requested that he be heard.

The CHAIRMAN. The only reason I raise that question is that we do have other witnesses who do represent phases of the Veterans' Administration that are under attack, and we would like to get along with this investigation as rapidly as possible.

Mr. McQUEEN. I think that he could touch on some points that have been attacked.

The CHAIRMAN. We are going to have to close here in a very short time to go back to the House.

Mr. CUNNINGHAM. May I have a word? I think one witness said the food was as "cold as the grave," but I do not think there was any criticism as to the quality of the food. It had to do with the preparation of it.

The CHAIRMAN. Yes, I do not understand that this branch of the Veterans' Administration was under attack at all.

Mr. CUNNINGHAM. There was some attack about concessions of canteens.

The CHAIRMAN. If it suits you all right, I would rather you submit your statement for the record and answer whatever questions we might have.

Mr. KIDD. Very well.

(The statement is as follows:)

STATEMENT OF RAYMOND C. KIDD, DIRECTOR OF SUPPLIES, VETERANS' ADMINISTRATION,  
TO THE VETERANS' COMMITTEE, JUNE 29, 1945

Mr. Chairman and members of the committee, the Supply Service of the Veterans' Administration is responsible for purchase, storage, and distribution of all supplies and equipment for all Veterans' Administration activities; accountability for all Government property, other than real estate, and auditing of property accounts; operation and management of supply depots; traffic management contracts, leases, and agreements for all Veterans' Administration activities except construction contracts. The director of this service is responsible to the Administrator through the Assistant Administrator in charge of medical and domiciliary care, construction and supplies.

The Administrator has instructed that I prepare a statement for presentation to this committee, setting forth difficulties and obstacles with which the Supply Service has been confronted in the procurement of materials, supplies, and equipment during the war period.

We first established liaison with the War Production Board in January 1942. Initially the most difficult problem we had was to explain to those in authority the functions of the Veterans' Administration and to convince them that it was an agency of the United States Government. We came in contact with many officials who, while they had heard of the Veterans' Administration, were of the opinion that it was a service organization such as the American Legion, and they were entirely ignorant of its functions. After finally establishing the fact that we were an agency of the United States Government charged with the responsibility of providing hospitalization and domiciliary care for veterans, we were told that as far as the War Production Board was concerned we were in the same category as any civilian hospital and would be treated accordingly. The first impact of the war required us early in 1942 to find substitutes for critical materials such as furniture steel, aluminum, corrosion resistant steel, brass, copper, and zinc. As a result we revised our specifications to specify wood for such items as nurses' desks, instrument cabinets, and office furniture; enameled ware for aluminum and corrosion resistant steel, and galvanized iron for other items in which high-grade steel, brass, and copper had been used. The life of the commodities manufactured from these substitute materials is, of course, limited and thousands of dollars will have to be expended later on for replacements. I don't know whether or not this is a fact, but it is reasonable to assume that had we, in the early days of the war, been declared to be a war agency, we would have gotten more consideration from the War Production Board and would have been able to purchase better merchandise, thus obviating later replacements of inferior goods at great cost.

The Servicemen's Readjustment Act of 1944 became law June 22, 1944, and declared the Veterans' Administration to be an essential war agency and entitled, second only to the War and Navy Departments, to priorities in personnel, equipment, supplies, and material under any laws, Executive orders, and regulations pertaining to priorities. The Administrator of Veterans' Affairs, under date of July 5, 1944, directed a communication to the Chairman, War Production Board, requesting information as to what procedure would be adopted by the War Production Board to make effective the provisions of the act relating to priorities

for equipment, supplies, and materials required by the Veterans' Administration. In response to this communication the Chairman, War Production Board, advised of the assignment of a representative of the Institutions Branch, Government Division, WPB, to take up the matter with appropriate Veterans' Administration officials. Several meetings held between representatives of the WPB and the Veterans' Administration during the summer of 1944 resulted in the revision of many WPB L and M orders to include the Veterans' Administration as a "preferred agency" which in effect meant that applications for priorities filed by the Veterans' Administration would receive more favorable consideration or other WPB assistance in securing requirements. However, as far as we have been able to ascertain, the Veterans' Administration was not officially recognized by the War Production Board as an essential war agency until September 4, 1944, on which date Mr. J. A. Krug, Acting Chairman, War Production Board, issued the following memorandum to all Bureau and Division directors:

"Under section 100 of the GI bill of rights, approved June 22, 1944, the Veterans' Administration is declared to be an essential war agency and entitled, second only to the War and Navy Departments, to priorities in personnel, equipment, supplies, and material under any laws, Executive orders, and regulations pertaining to priorities. The provisions of this section as to priorities for material also apply to any State institution to be built for the care or hospitalization of veterans.

"It is the desire of the War Production Board to recognize fully this section of the act, and to put it into effect, as far as consistent with the general scheme and purpose of priorities controls, in matters falling within the province of the Board. As you know, the Veterans' Administration is primarily engaged in constructing, equipping, and maintaining hospitals. Accordingly, I have instructed the program vice chairman to communicate to you specific suggestions as to order amendments, procedural changes, and other actions which appear appropriate to him to carry out the above-expressed policy. Your cooperation in doing so is requested."

On September 5, 1944, Mr. S. W. Anderson, program vice chairman, War Production Board, issued a memorandum to all bureau and division directors, reading in part as follows:

"Reference is made to Mr. Krug's memorandum of September 4, calling attention to the change of priority status of the Veterans' Administration created by section 100 of the act of June 22, 1944. It is necessary that prompt steps be taken in our orders, regulations, and procedures for priority assistance to make this change of status effective.

"The statute states that Veterans' Administration is declared to be 'An essential war agency and entitled, second only to the War and Navy Departments, to priorities \* \* \*'. We take this to mean that in all cases where the direct or indirect essential requirements of the Army and the Navy will not be interfered with the Veterans' Administration should be given the same kind and degree of priority assistance given the Army and the Navy. Where the essential requirements of the Army and the Navy will be interfered with by such treatment for the Veterans' Administration, some lesser, but nonetheless adequate, assistance should be provided.

"It will be necessary to look at each order and product in order to determine the particular provision that should be made. Under some orders which give blanket exemptions for the Army and the Navy (sometimes together with the Maritime Commission, the War Shipping Administration, lend-lease, etc.), it would be appropriate, considering the supply of the material or product and the requirements of the Veterans' Administration, to include the Veterans' Administration in the exemption. In any case where a blanket exemption is given to some agency other than the Army and the Navy a strong case will be necessary to justify the exclusion of the Veterans' Administration. This will apply to M orders as well as to L orders.

"In some cases the preferred status given the Army and the Navy is evidenced by special forms or processing instructions which simplify the paper work and otherwise expedite the delivery of the final product. Consideration should be given to providing this same procedure for the Veterans' Administration.

"It should be borne in mind that the Veterans' Administration is engaged primarily in building, equipping, and maintaining hospitals. The materials and equipment which are used in such operations and the time. Further, the Veterans' Administration operates on limited appropriations and its programs have received careful screening before they come to the War Production Board. Here they will be screened again by the Government Division, the Requirements Committees, and the Facilities Bureau. Its new construction programs are designed



to care for the sick and disabled soldier returning from the present fighting, as well as the veterans from our previous wars. Congress has recognized the urgency of these programs. We can and should do no less."

The failure of the War Production Board to accord the Veterans' Administration the status it rightfully deserved prior to the passage of the Servicemen's Readjustment Act of 1944 greatly handicapped our operations, and a few illustrative examples of delays in securing merchandise are as follows:

#### TEXTILES

A contract for material to be used in the manufacture of pajamas in occupational therapy projects in neuropsychiatric hospitals was awarded June 30, 1943, the contractor indicating that a rating of AA-5 would be required to effect the delivery. After several personal contacts with WPB, who indicated no rating was required, formal application for a rating was made and finally approved September 10, 1943. The rating assigned, namely, AA-5, was extended to the contractor, who then advised that because of the delay in securing the rating it would not be productive of results, and it was necessary to cancel the contract. A new contract was then awarded and this contractor was able to procure the material on an AA-5 rating. Had the War Production Board authorized the AA-5 rating as originally requested, much delay in the procurement of the material would have been avoided and a saving of approximately \$6,000 would have been effected.

Under date of September 11, 1943, a contract for supplying burial suits, used in connection with the burial of deceased veteran patients, was awarded and the WPB refused a priority, claiming material was available without rating. This proved to be not a fact and finally a rating was granted under date of February 21, 1944, but the rating authorized was too low to enable the contractor to procure sufficient material to complete his contract, and at this date a portion of the contract is unfilled.

Ratings sufficiently high to enable manufacturers to procure material from which to manufacture flags within a reasonable time to drape the caskets of deceased veterans have been refused, which has caused long delays in procuring this commodity.

Failure to extend appropriate rating to permit procurement of sheeting required for essential activities has been a handicap and resulted in our being without this commodity for nearly 2 years, and when our need became desperate the WPB finally authorized a rating high enough to enable us to procure this product.

The War Production Board has been and is continually denying ratings to secure items of haberdashery, such as underwear and shirts, so essential for the comfort and welfare of veterans in our facilities.

The shortage of cotton clothing in various sections of the country has become so acute that it has been impossible for our facilities to procure clothing for mentally incompetent patients with funds, and as a result it has been necessary as an administrative necessity to authorize the sale of Government-owned merchandise to properly clothe those patients. Unless relief is forthcoming in the very near future, the stock of cotton clothing purchased by the Veterans' Administration for issue to patients without funds will become exhausted—in fact, some sizes are already exhausted, with no replenishment in sight. Appropos this matter, it is a well-known fact that cotton woven fabrics are being manufactured and exported for relief purposes. While I am not qualified to pass judgment upon this policy, the fact remains that the Veterans' Administration will be subjected to severe criticism, and properly so, if the time ever comes when the patients in its hospitals cannot be properly clothed.

#### MEDICAL EQUIPMENT

A few illustrations under this heading will suffice to indicate our difficulties.

Rating denied for electrocardiograph and as a result approximately 150 days required to effect delivery when contractor could have made delivery in 30 days with an AA-1 rating.

WPB Order L-259 prohibited the manufacture of short-wave diathermy machines except for Army and other preferred agencies. While equipment of this nature was urgently needed in our hospitals, the War Production Board would not waive the restrictions in the order to permit manufacture for the Veterans' Administration. To procure several machines most urgently needed, the Office

of the Surgeon General, United States Army, was good enough to procure them for the Veterans' Administration.

Long delays were encountered in the procurement of shock-therapy apparatus because of the refusal of the War Production Board to grant appropriate priority ratings, and it was not until the Administrator made an appeal to the Chairman, War Production Board, that ratings to secure delivery were issued.

The War Production Board in one instance refused to issue a priority for the procurement of a steam jacketed disinfecter to be used for sterilizing mattresses. The reason given for denying the application was that critical materials entering into the construction of the equipment were needed for more essential uses by the armed forces and suggested that in the absence of this type of equipment mattresses be sterilized by exposure to the sun and air.

The WPB did, however, issue certain orders and regulations which were beneficial to the Veterans' Administration; namely, CMP Regulation 5A, promulgated in November 1943 authorizing an AA-1 rating for maintenance and repair materials, Orders P-140 and P-146 authorizing ratings to procure certain shipping containers, and P-43 and L-144 authorizing ratings to procure laboratory supplies and equipment. The ratings authorized under these orders were effective in procuring deliveries.

While I have said much in criticism of the War Production Board because of its treatment of the Veterans' Administration, I feel that in fairness to WPB we should not lose sight of the fact that the primary function of this Board was to take every step necessary to make materials available for the prosecution of the war. To do this, it was necessary that materials in every category be placed under control for diversion to the extent needed to the war effort. To accomplish this, it was no doubt necessary to deny materials to agencies other than those activities engaged in the prosecution of the war until such time as it could be determined that materials not required for this purpose would be available. Such a program naturally affected the Veterans' Administration, and there is some question in my mind as to whether priorities second only to the Army and Navy would have been of much assistance in the early days of the war, for the reason that there was only so much material of a given kind and Army and Navy orders were rated sufficiently high to enable them to get this material. A priority rating does not necessarily guarantee early delivery of a commodity; a priority simply is the means used for establishing the sequence in which rated orders will be delivered. Under a disrupted economy such as we have experienced in the last 4 years, many of the delays which have obtained in the procurement of materials and equipment could not, in my judgment, have been avoided.

#### FOOD

*Sugar.*—The first item of food on which the impact of the war was felt was sugar. Under date of January 24, 1942, the War Production Board issued General Preference Order No. M-55 "to conserve the supply and direct the distribution of direct-consumption sugar." This order fixed the quotas for distributors and receivers of sugar but provided that it would not apply to "any person, for retail sale, on military or naval reservations or naval vessels, to military or naval personnel." This order also exempted from its provisions the War and Navy Departments. The Supply Service, immediately upon receipt of the order, took up with the War Production Board the matter of exempting the Veterans' Administration, and under date of February 3, 1942, was informed by letter from the War Production Board to the effect that it had been administratively determined that hospitals and homes for veterans of the last war and for disabled veterans of the present war come within the provision of the order exempting "any person, for retail sale, on military or naval reservations or naval vessels, to military or naval personnel." This interpretation of the order by the War Production Board was not questioned, although it was apparent that the provision in the order above quoted properly could not be interpreted to exempt the Veterans' Administration from the provisions of the General Preference Order.

Under date of April 4, 1942, the War Production Board advised that based upon a definition by the War Department of the term "military or naval reservation," the sugar requirements of the Veterans' Administration were not exempt from the provisions of the General Preference Order, and that the Veterans' Administration would no longer be entitled to purchase quota-exempt sugar without having explicit authority from the Director of Industry Operations, War Production Board. The Supply Service under date of April 11, 1942, requested



an exemption and under date of April 24, 1942, the War Production Board advised as follows:

"Reference is made to your letter of April 11. As you may know, registration of institutional users of sugar will be conducted by the Office of Price Administration April 28 and 29. At that time we understand you will have an opportunity to explain your problem to your local OPA rationing board which should provide an equitable basis for analyzing your requirements.

"Since there is such a short time between now and the actual inauguration of the rationing program, it is not feasible for this office to make adjustments in the sugar allotments to the various classes of users.

"We therefore suggest that you follow the above procedure and address any further communication in this respect to the Office of Price Administration."

The above decision of the War Production Board meant that we would have to register with the OPA and procure our sugar in the same manner as civilian hospitals. However, we did not register at that time due to the fact that we had a good stock of sugar in our supply depots to meet our needs for a considerable period of time. If we had not exercised foresight in procuring this sugar, we would have faced an embarrassing situation.

The refusal of the OPA to classify the Veterans' Administration as an agency entitled to purchase quota-exempt sugar was brought to the attention of the Administrator under date of April 30, 1942, and as a consequence he commented as follows:

"I agree with you thoroughly that the close relationship of the Veterans' Administration to the war effort should entitle it to the same exemption from rationing as the Army and Navy and to that end will you please prepare for my signature a letter to Mr. Leon Henderson, Administrator, Office of Price Administration, asking for exemption and indicating the necessary close cooperation between the War and Navy Departments and the Veterans' Administration and the load of cases already coming to us from these sources requiring care and the progressive increase of this load."

A communication over the Administrator's signature was addressed to Mr. Leon Henderson under date of May 14, 1942, requesting that "Rationing Order No. 3—Sugar Rationing Regulations" be amended to authorize the Veterans' Administration to procure sugar under the same procedure as authorized for the Army and Navy. This letter was sent to Mr. Henderson by messenger and delivered to Mr. Henderson's secretary. No response was received and a follow-up over the Administrator's signature was mailed under date of June 18, 1942, to which no response was received. The matter was further pursued with the OPA in a further attempt to have the Veterans' Administration placed in the same category as Army and Navy, but without results. Finally, on or about September 1, 1942, the OPA amended its regulations, placing the Veterans' Administration hospitals into two classes; namely, (1) those engaged in the care of patients who are acutely ill and who temporarily live within the hospital for medical or surgical care and (2) those principally treating chronic cases or mental illnesses and providing domiciliary care. Under date of September 15, 1942, these classifications were protested in a letter to Mr. Henderson over the Administrator's signature without results. Finally, as a last resort, I appeared before the ration board for this area and registered for Veterans' Administration hospitals. We received our sugar allotments for the preparation for service and service of food for patients on the basis of 85 percent of the amount of sugar used for such purposes during the corresponding month of 1941 and for the preparation for service and the service of food for members (domiciliary) on the basis of 60 percent of the amount used for such purposes during the corresponding month of 1941. These allocations were insufficient and we had numerous complaints from hospitals, service organizations, etc., as to the lack of sugar. The problem relating to the procurement of sugar was not solved until the early part of 1943, at which time our requirements were allocated by the Department of Agriculture under the food-allocation plan hereinafter discussed.

*Coffee.*—The OPA issued an order rationing coffee for the period beginning November 22, 1942, and ending January 31, 1943. During this period our hospitals were not permitted to receive more coffee than was used during September and October 1942. For the month of February 1943 the allotment was 40 percent of the quantity of coffee used during the base period, September and October 1942. Coffee rationing was finally lifted under date of July 29, 1943, but during the period of rationing we had many complaints because of insufficient quantities of coffee and we could not get any exemption for the Veterans' Administration.



*Meats and fats and other foods.*—We did not encounter any particular difficulties in the procurement of meats and fats until the latter half of the calendar year 1942, when we began to feel the shortages in these commodities. Fortunately the President, under date of December 5, 1942, issued Executive Order 9280 giving the Secretary of Agriculture authority to control the distribution of food, including that required for military as well as other governmental agencies. The Executive order also authorized the Secretary of Agriculture to purchase and procure food for such Federal agencies, and to such extent, as he shall determine necessary or desirable, and promulgate policies to govern the purchase and procurement of food by all other Federal agencies.

The Executive order also instructed the Secretary of Agriculture to appoint a committee to advise and consult with him in carrying out the provisions of the order. The contents of this Executive order were brought to the attention of the Administrator on December 18, 1942, recommending that the Veterans' Administration be permitted to designate a representative to serve on the committee provided by the executive order. The Administrator approved this recommendation and accordingly a communication was addressed to the Secretary of Agriculture under date of December 21, 1942. No response was received to this letter and finally the Administrator had a personal conference with the Secretary of Agriculture, who promised that he would give consideration to our being represented on the advisory committee. On January 16, 1943, the Secretary of Agriculture advised that certain committees to expedite and coordinate food procurement and allocation were being established, and asked the Administrator to designate representatives to serve on these committees. Colonel George E. Ijams, Assistant Administrator, was designated as the regular member of these committees, and the Director of Supplies was designated to serve as alternate, in letter dated January 22, 1943, over the Administrator's signature to the Secretary of Agriculture. These officials attended the first meeting of the Interagency Food Procurement Committee on January 28, 1943, and the minutes of this meeting report Colonel Ijams as having made the following comments:

"1. Col. G. E. Ijams of the Veterans' Administration indicated that the canned fruit and vegetable operations of last year were very successful and he saw no reason why they should not be applied to other commodities.

"Colonel Ijams said that this organization is having difficulty in getting certain foods for hospitals, particularly meats, butter, and eggs. Over 80,000 men are hospitalized in the hospitals of the Veterans' Administration. They must be supplied with proper food. As the war progresses, more food will be required inasmuch as veterans' hospitals take in men of a military liability character; that is, men who cannot be rehabilitated as fighting men. The Army and Navy take care of wounded men in the initial hospitalization period. Colonel Ijams indicated that his organization is getting increased production from its own farm operations, particularly on hogs."

Subsequent to the first meeting of the Interagency Food Procurement Committee, Colonel Ijams and the Director of Supplies had conferences with representatives of the Department of Agriculture at which they insisted that the Veterans' Administration should be placed in the same category as the Army and Navy, which at first was refused but finally granted and under date of May 15, 1943, the Director, Food Administration Division, issued an order including the Veterans' Administration as an agency for which separate food allocations would be made in the same manner as for the Army and Navy. This promulgation of policy simplified food procurement in that it removed us from the category of civilian hospitals subject to OPA rationing regulations. Under this policy the Department of Agriculture certified our requirements of rationed food items to OPA and OPA issued ration currency to be handled by us through the ration banking system.

*Canned fruits and vegetables.*—Prior to the promulgation of the above-indicated policy, through a cooperative arrangement sponsored by the War Production Board, our requirements for canned fruits and vegetables were pooled with those of the Army and Navy, and in 1942 were purchased by the Army. After the matter of determining food policies was transferred to the Secretary of Agriculture, a similar arrangement has been in effect and at the present time the Army is purchasing our canned fruits and vegetables. This job has been performed by the Army through General Hardigg to our entire satisfaction.

As the food situation became more critical, our hospitals found it more and

more difficult to procure locally certain items of perishable food, particularly meats and poultry, and through an arrangement made with the quartermaster market centers, functioning under General Hardigg, these centers have been most helpful in providing our needs for these scarce commodities and this arrangement is working to our entire satisfaction.

*Set-aside orders.* In order to provide the needs of the armed forces, it was necessary in the early part of 1943 for the Department of Agriculture to promulgate "set-aside orders." These orders relate to certain scarce food commodities such as fresh meats, canned fish, butter, powdered skimmed milk, etc., and the Veterans' Administration is included in these set-aside orders along with the armed forces.

I wish to conclude my statement concerning food by paying tribute to the officials in the War Department and the War Food Administration who have cooperated to the fullest extent in our program, particularly General Hardigg, of the Subsistence Branch, Quartermaster Corps, United States Army, and Lieutenant Colonel Olmstead, Director, Office of Supply, War Food Administration. These officials have displayed an outstanding attitude of cooperation and understanding, and both have stated on several occasions that every essential need for food for veterans in our hospitals will be provided.

#### PREPARATION MADE IN ANTICIPATION OF INCREASED NEEDS FOR BEDS

In April 1941 the Supply Service, because trends indicated scarcity and long deliveries, instituted a procurement program to stock pile, within reason and availability of funds, textile products such as bathrobes, bedspreads, sheeting, towels, underwear, and outer clothing. This move proved to be a wise one for the reason that immediately after our stocks were procured, commodities of this character were in very short supply.

In the early part of January 1942, Colonel Ijams, Assistant Administrator, and the Director of Supplies conferred with the Administrator and suggested that action be taken immediately to procure certain basic equipment for additional beds to be made available for emergency use, which he agreed should be done, and under date of January 17, 1942, it was recommended to the Administrator that he authorize the procurement of sufficient basic equipment to provide 2,500 beds for general medical and surgical cases and 3,000 beds for NP cases. Inasmuch as funds were not available at that time for the procurement of this equipment, the cost thereof was included in an emergency appropriation which was granted in May 1942, and the equipment in question was procured.

On May 28, 1942, Colonel Ijams recommended to the Administrator that he authorize procurement of sufficient basic equipment to provide an additional 7,500 beds at existing NP facilities at an estimated cost of approximately \$640,000. This equipment was eventually authorized for procurement in the latter part of the fiscal year 1943, procurement not being made earlier because of lack of funds, and at no time during the national emergency has the Supply Service been unable to supply immediately basic equipment required to provide a bed.

For years after World War I, the Veterans' Administration maintained a depot in the central manufacturing district of Chicago for storing and distributing supplies to facilities in the Middle West. This depot was located in the quartermaster supply depot under a revocable license issued by the Secretary of War. Soon after the establishment of the Civilian Conservation Corps the Veterans' Administration was required by the War Department to relinquish part of this space which, to a certain extent, cramped our operations, but, notwithstanding, we got along fairly well. However, early in 1939, when it appeared that we could have no assurance of continuing occupancy of space in the quartermaster depot and in view of the preparations then being made for national defense, it was recommended to the Administrator that he favorably consider the construction of our own depot. This recommendation was approved and future developments confirmed the wisdom of the decision. I have given these illustrations of advance planning made by the Veterans' Administration for the purpose of indicating to the committee that those responsible for providing supplies foresaw and took effective action in advance of actual development of need. I would not, however, contend or attempt to leave you with the impression that we have not on occasions made mistakes or that there have been no delays in providing equipment and supplies. We have made mistakes and there have been delays, but such things will happen in any organization, in or out of the Government.



## SPACE FOR EXPANSION

Section 101, title I, Servicemen's Readjustment Act of 1944, authorizes and directs the Administrator of Veterans' Affairs "to establish necessary regional offices, suboffices, branch offices, contact units, or other subordinate offices in centers of population where there is no Veterans' Administration facility or where such a facility is not readily available or accessible."

Many obstacles confront the Veterans' Administration in securing space to make effective the above-cited legislation. Section 3769, Revised Statutes as amended, provides that no Department of the Government shall expend in any one fiscal year any sum in excess of appropriations made by Congress for that fiscal year or involve the Government in any contract for the future payment of money in excess of such appropriations. Consequently the Veterans' Administration, in leasing property to be used for regional offices, branch offices, and contact offices, may bind the Government only to the end of the fiscal year in which the leases are consummated, with an option of renewal from year to year for a specified number of years. Owners of property are reluctant to lease space under these conditions, particularly where the area is large or extensive alterations are required, as they have no assurance that the leases will be renewed. Many times the only space available in a locality and adequate for the purpose is offered upon the condition that the owner be given a firm lease for a period of 5 years. In cases of this kind it is necessary for the Veterans' Administration to ask the Public Buildings Administration, Federal Works Agency, to negotiate the lease, as this agency has statutory authority to make a firm lease for 5 years. Such an arrangement, which requires the Veterans' Administration to acquire its needs through another agency, is not entirely satisfactory.

Section 322 of the Economy Act of June 30, 1932 (46 Stat. 412), provides that appropriations shall not be obligated or expended for the rental of any building or part of a building to be occupied for Government purposes "at a rental in excess of the per annum rate of 15 per centum of the fair market value of the rented premises at date of the lease under which the premises are to be occupied by the Government or for alterations, improvements, and repairs of the readied premises in excess of 25 per centum of the amount of the rent of the first year of the rental term or for the first rental term if for less than one year." The provisions of this section as applicable to rentals do not apply where the rental is not in excess of \$2,000 per annum.

Many difficulties arise in establishing the fair market value of property, and we are confronted repeatedly with cases where the rental asked for the only space available and adequate for our purposes exceeds the above limitation, or the information received regarding the fair market value is not supported by certification of a competent Government authority as required by the Comptroller General. Other cases arise where the cost of the extensive alterations required at Government expense to adapt the space to our needs is in excess of the limitation of the Economy Act. It is then necessary for the Veterans' Administration to request the War Department to issue a certificate of necessity under the provisions of the act of April 28, 1942 (56 Stat. 247), to permit the Veterans' Administration to proceed. The authority to issue said certificates is delegated only to the Secretary of War and the Secretary of the Navy, and their designates.

Appropriations of the Veterans' Administration are not available for the construction or the purchase of buildings for regional offices, branch offices, and contact units. Desirable buildings are sometimes offered for sale and not for lease, and the Veterans' Administration is handicapped in not being able to purchase such buildings.

Authority to take by the exercise of the right of eminent domain a leasehold interest in property has not been extended by law to the Administrator of Veterans' Affairs.

Although the Veterans' Administration was declared to be an essential war agency by title I, section 100, Public Law 346, Seventy-eighth Congress, the Veterans' Administration has no priority rights as affecting the acquisition of space. Some of our offices are now established, and have for some time been established, in federally owned buildings, and our expanded space requirements could be met by the removal from the buildings of other Federal agencies. With no priority rights this is a difficult matter, and although we have offered to pay the rental of certain agencies and the cost of removal of their office equipment to



outside space, we have run into many difficulties, and we have not been highly successful in effecting the removal of other Federal agencies. At the present time the Veterans' Administration has been unable to find suitable space for regional office purposes in Nashville, Tenn.; Knoxville, Tenn.; Chicago, Ill.; Detroit, Mich.; Newark, N. J.; Portland, Oreg.; and San Francisco, Calif.

Apropos the subject of supply, I wish to state that 10,000 or more commodities are used in the operation of Veterans' Administration hospitals and other activities. These supplies range in nature from pens and paper used by all employees, regardless of position, to highly technical equipment used by our professional personnel. During this war period there have been times when certain commodities were not available and this situation could not be avoided. Curtailment of production or the diversion of critical materials to war purposes mainly have been the cause of our inability to furnish certain commodities. However, on the whole the Supply Service has been able to provide what has been needed by anticipating requirements and placing contracts long in advance of actual need. In many instances it has been necessary to anticipate requirements at least 1 year. No hospital has suffered for the lack of food, and while there have been instances when some of the hospitals could not procure the exact commodity desired, the hospitals have been able to maintain an adequate diet for the patients. As of this date the most difficult items of food to procure are fresh and cured meats, poultry, and eggs.

#### PERSONNEL

Although the personnel situation in Supply is now showing some improvement, until recently, and for months, approximately an average of 20 percent of our authorized positions were vacant, and since the early part of 1942 there has been an unusual turn-over in personnel. These vacancies and the turn-over have prevented maximum production as Supply work is more or less technical and inexperienced personnel are not productive of satisfactory results until they have been on the job a considerable period of time. Personnel conditions have, therefore, been a serious handicap in the performance of our functions.

R. C. KIDD,

*Director, Supply Service.*

Mr. MATHEWS. May I add this, sir, that if Mr. Kidd happens to know of some specific point that has been raised in this investigation, it might be well for him to mention that.

The CHAIRMAN. Yes.

Mrs. ROGERS. Mr. Chairman, there was, I know, a great delay in some hospitals receiving Streicher beds and Vulcan frames for the neurosurgical cases and any amputees they might have.

Mr. KIDD. That is correct, Mrs. Rogers, but the Streicher frames that you speak of are manufactured in this country by only one concern, which has a very small organization, and they had difficulty in getting material from which to construct these beds; in fact, we had to go to the Army quartermaster and procure material ourselves to supply this manufacturer; so there have been delays of that kind for those reasons.

Mrs. ROGERS. That is one reason some of the patients were in such bad condition?

Mr. KIDD. Yes, ma'am.

Mrs. ROGERS. Of course, in the Boston city hospital they made their own Vulcan frames out of piping.

Mr. KIDD. I believe that is correct.

Mrs. ROGERS. Yes. I saw the beds. They did not have them for months and they also did not get the medical supplies as quickly as they ought to.

The CHAIRMAN. You did not have the priority the War Department had, either, did you?

Mr. KIDD. No, sir; that is right, sir. I touch on all that in my statement, Mr. Chairman.

The CHAIRMAN. Well, you submit your statement for the record.

Mr. MATHES. Mr. Chairman, this morning some member of the committee asked about efforts to recruit nurses. I have the figures, I can just state them briefly and then put the detail in the record, if you wish. They sent out a little over 20,000 cards to graduating student nurses. They get about 2,000 replies. To those 2,000 they sent the application for employment blank and the net result, without telling the horrible details, were that they hired 35 nurses out of the 20,000 cards they sent out.

The details are set forth in this exhibit, which Dr. Griffith did not have with him this morning.

The CHAIRMAN. That may be submitted for the record.

Mr. MATHES. It may be a part of Dr. Griffith's testimony, sir.

The CHAIRMAN. Yes.

(The statement will be found at the end of Dr. Griffith's testimony.)

Mrs. ROGERS. And did they not feel that it was because the Bureau did not have enough to offer?

Mr. MATHES. We have no information as to why they did not respond.

Mrs. ROGERS. I would like to have that go into the record, too, Mr. Chairman, the reason that the Medical Department thought the nurses did not enlist.

Mr. MATHES. There is no information available because they did not state any reasons.

Mrs. ROGERS. But I would like to get it, Mr. Chairman.

Mr. MATHES. I will try to get that information for you.

Mrs. ROGERS. Thank you. I would like to have it.

The CHAIRMAN. It may be submitted.

(The information is as follows:)

In the opinion of the nurse recruitment specialist the low number of nurses secured from the phenomenally high percentage of replies to direct mail campaign (February to June 1945) can be attributed to the following:

1. Subprofessional rating of Veterans' Administration nurses.
2. Salaries below competitive level.
3. Lack of progressive educational and professional program.
4. Danger of isolation at out-of-the-way stations.

These conclusions are substantiated by the Office of War Information in a letter dated May 2 to the Medical Director from Mr. David Frederick, Director of War Programs, from which the following is quoted:

"\* \* \* for the past several weeks our regional radio facilities have been used in this recruitment effort. From replies thus far, it is evident that these efforts have not been too successful. It is our view that it is not the fault of the media employed but what is offered the graduate registered nurse who is being asked to seek employment in Veterans' Administration hospitals, plus competition for the nurse's service.

"Competition for nurses above the military age has, in our opinion, tended to make your recruiting more difficult because the salaries paid to nurses under civil service do not come up to the salaries paid in civilian work. Too, there is the objection on the part of graduate registered nurses to the semiprofessional rating given them under the civil-service classification."

**STATEMENT OF COL. GEORGE E. IJAMS, ASSISTANT  
ADMINISTRATOR, VETERANS' ADMINISTRATION**

Mr. McQUEEN. State your full name for the record.

Colonel IJAMS. George E. Ijams, Assistant Administrator of Veterans' Administration.

Mr. McQUEEN. How long have you been in that capacity with the Veterans' Administration?

Colonel IJAMS. Twenty-six years on the 20th of this month; not just with the Veterans' Administration, but its predecessor organizations, in the same capacity.

The CHAIRMAN. That is the War Risk Insurance?

Colonel IJAMS. Assistant Director of the Bureau of War Risk Insurance, Assistant Director of the United States Veterans' Bureau, and Assistant Administrator of the Veterans' Administration.

Mrs. ROGERS. You started with Col. Cholmeley-Jones, did you not?

Colonel IJAMS. Yes, I did, Mrs. Rogers. He and I had been in France together and Colonel Lindsey, who had preceded him, wired me and asked me to come back as his assistant. I did not reply to the wire, and when I returned, I found that Colonel Cholmeley-Jones had also wired me but I was in Brest waiting to come home and did not get his wire. He phoned my home at Baltimore and got me to come over.

Mr. Chairman, I have a prepared statement which I would prefer to read if possible, because I have tried to cover not only the broader aspects of this situation but also to answer certain statements that I have heard made here in proceedings before the committee.

The CHAIRMAN. How long will it take?

Colonel IJAMS. About 15 or 20 minutes.

The Veterans' Administration is one of the world's largest and most important relief agencies. It was created by the Congress of the United States to render many kinds of service, care, and treatment earned by the soldiers and sailors of our country who have defended us in time of war.

Mr. SCRIVNER. Mr. Chairman, might I interrupt? Is it necessary to leave in that statement that it is a "relief" agency?

Colonel IJAMS. Not at all, sir.

Mr. SCRIVNER. Well, I hope you strike it out.

Colonel IJAMS. All right, I will be glad to.

Mr. SCRIVNER. Because I just do not like that word applied to services rendered to veterans.

Mr. ODOM. Say "service."

Colonel IJAMS. Very well—largest and most important service agencies.

Mr. SCRIVNER. That is much better. That is what it is, it is a service agency.

Colonel IJAMS. Glad to do it, Mr. Scrivner.

Its male personnel consists very largely of war veterans, many of whom have sons and daughters in the armed services in World War II. Not only does the Veterans' Administration care for disabled men requiring hospitalization or domiciliary care but it operates the largest insurance company the world has ever seen; it pays monetary benefits to those who have suffered disease or injury in our defense, and to the widows and orphans of the thousands who have made the supreme



sacrifice for this country. It also provides monetary, educational, vocational training and other benefits to men and women who have served honorably in time of war.

The Servicemen's Readjustment Act of 1944 was approved by the President on June 22 of that year, and shortly prior to the passage of that legislation Congress had passed a law granting hospitalization to all honorably discharged veterans irrespective of the time they spent in the service, a benefit which was not granted to veterans of World War I until years after the close of that conflict.

In this brief manner I am citing many of the activities of the Veterans' Administration which require a great deal of work and careful adjudication of millions of claims. I am stressing the scope of our activities because in the recent sessions of this committee so much time and thought have been directed to the operation of our hospitals that I fear some persons may possibly overlook the fact that the operation of our hospitals is only one of the many major problems confronting our organization.

I hope that the members of this committee have carefully observed the organization chart of the Veterans' Administration which has been furnished you. I feel confident all will realize that the Administrator of Veterans' Affairs personally could not possibly cope with all of the problems of administration that arise in the numerous services and divisions of this great organization. For this reason he has appointed certain assistants and has assigned to them certain related activities which require constant coordination in order that they may function as expeditiously as possible. The various services are organized under and are operated by specially trained directors whose duty it is to carry out the functions of their respective responsibilities and to operate their services with the assistance of carefully chosen staff officers. These assistants are as necessary to the successful performance of the service directors as are the Administrator's assistants to him.

The Director of Supplies is responsible for the purchase, storage, and distribution of all supplies and equipment for all Veterans' Administration activities. He is accountable for all Government property and auditing of property accounts; the operation and management of supply depots; and the execution of contracts, leases, and agreements for all Veterans' Administration activities except construction contracts.

The Director of the National Homes Service is responsible for all matters relating to domiciliary care of beneficiaries and claimants under the laws relating to the Veterans' Administration.

The Director of Construction is responsible for the preliminary inspection and engineering work in connection with the selection of sites for new facilities; preparation of plans, specifications, and estimates covering construction, alteration, and repair of plants and equipment and supervision of performance of such work; for maintenance of contact with other services, bureaus, and Government departments; for the supervision of maintenance of buildings, grounds, and mechanical equipment under the control of the Veterans' Administration, and for all similar work pertaining to construction or maintenance of our facilities throughout the country.

The Medical Director is in charge of the Medical and Hospital Service; is responsible for all medical and dental services rendered claimants and beneficiaries entitled thereto under the laws and regula-

tions governing the operation of the Veterans' Administration. He is also responsible for the medical and dental treatment and care for hospitalized patients and for out-patients rendered at field stations or in the homes of entitled beneficiaries. The Medical Director is also responsible for physical and laboratory examinations which may be required for adjudication purposes or for the purpose of medical treatment.

It will be clearly seen from the above description of duties that there is no one in the Veterans' Administration with authority to handle medical diagnosis, treatment, and medical care except the Medical Director and his subordinates. I am stressing this point because many persons appearing before this committee have given the impression that the Medical Director is subordinated to others insofar as the practice of medicine is concerned. This is absolutely untrue and I know of no instance in the 26 years that I have been in my present position where anyone in our organization who is not a physician has ever even suggested what medical treatment should be given to any patient in our hospitals, and if I may inject there, Mr. Chairman, the Medical Director confirmed that this morning in his statement.

Mrs. ROGERS. May I ask a question just at that point?

Colonel Ijams, who is responsible for the promotion of doctors? As I understood Dr. Griffin—

The CHAIRMAN. Do you mind withholding that until he finishes his statement?

Mrs. ROGERS. That is all right. I wanted to be sure it was answered because that has very much to do with the care of the patients, Mr. Chairman.

Colonel IJAMS. Mrs. Rogers, there is only one person responsible for the promotion of anyone in the Veterans' Administration; those subordinate to the Administrator may recommend but the Administrator must approve. The Medical Director can and has and does recommend promotions.

Mrs. ROGERS. I gathered Personnel has a good deal to do with it—

Colonel IJAMS. It goes through Personnel; yes.

Mrs. ROGERS. Yes; from Dr. Griffith to Personnel, and Personnel to the general?

Colonel IJAMS. That is correct.

Mrs. ROGERS. Because that does fit into the care of the patients very much, Mr. Chairman.

Colonel IJAMS. Yes; it does.

Mrs. ROGERS. Thank you.

Colonel IJAMS. I feel confident that the present Medical Director and all the other Medical Directors through the years will testify to the truth of this statement. It is most important that the members of this committee and the public should have clearly in mind that the Medical Director of the Veterans' Administration is the supreme medical authority of our organization.

It is also important for all to realize that in all hospitals there are two distinct jobs to be done—one is the treatment of patients, the other is the hotel or housekeeping job. In most private institutions of healing private doctors are employed for the treatment of their patients in the hospitals. These hospitals also maintain a staff of resident physicians and interns who continue the treatment prescribed by the



private physician when he is not present and who handle any emergencies which arise in the absence of the physician in charge of the case.

In Veterans' Administration hospitals all of our physicians of the various specialties are available for the care and treatment of all of our patients whenever their specialized services are required. Our laboratories are fully staffed and we maintain 24-hour service with graduate resident physicians always on the job day and night.

There are many problems in the operation of a hospital other than the practice of medicine. I have mentioned the hotel or housekeeping problem. This includes construction of the buildings, their maintenance, and the purchase and distribution of supplies required by the physicians at the time and place when they are needed. This work is not related to the practice of medicine except that it provides for the doctor those things which he requires in the treatment of his patients.

In order that this committee may have a clear picture of the situation which confronted our Medical, Domiciliary, Construction and Supply Services just prior to our entry into World War II and the difficulties experienced by us as a result of this war, I wish to make the following comments.

In the summer of 1941 we had an ample number of general medical and surgical and tuberculosis beds to meet all of our needs. We also had a sufficient number of neuropsychiatric beds for our then known requirements. In fact, the increases in our patient load had been rather gradual during the preceding several years and we had been able to meet all demands for beds by building approximately 3,000 beds per year. In 1940 our war industries had mushroomed in growth as we assumed contracts to supply the Allies with war materials. This brought demand for workers in these war factories at high wages. This situation in turn had quite a material effect upon our general medical and surgical hospitals. We found that men who came to us for minor surgical care when they were unemployed or were employed at low wages, were postponing medical care of this character because they were employed in war plants at high wages. As a result the load of patients in our general medical and surgical hospitals gradually diminished.

Shortly after World War I we had approximately 28,000 men in our hospitals suffering from tuberculosis, but this load had gradually diminished until we had only approximately 4,500 beds devoted to tuberculous cases in the summer of 1940. The number of our psychiatric cases had gradually increased through the years. Naturally, employment opportunities in war industries were not open to men suffering from tuberculosis and neuropsychiatric diseases. Consequently, employment opportunities in war industries produced no vacant beds from these two types of hospitals.

Because our construction work consisted principally of maintenance and operation and the construction of approximately 3,000 beds a year, the force of trained employees in our construction service had been materially reduced.

Prior to Pearl Harbor our supply activities were in splendid condition. The volume of work had materially increased as we expanded our hospitals and domiciliary homes, but ample supplies were available and prices were moderate.



War industry jobs also brought about a decline in the number of domiciliary cases in our soldiers' homes. Even though many of these men had been domiciled in our homes over a long period of years they were able to secure employment at high wages, and I might say there that when that occurred, I realized we were scraping the bottom of the barrel, because many of them were not really employable. Very briefly, that is the picture in the summer of 1940.

It will be recalled that some months prior to Pearl Harbor we determined to organize what we called a training army and the results of this mobilization soon manifested themselves insofar as our hospital load was concerned. Many men taken into the training army could not stand the rigorous courses of training and broke down from both physical, mental, and nervous conditions. Large numbers of these men were discharged from the service and transported to veterans' hospitals for continued care because the Army and Navy lacked hospital facilities for mental cases. We had no difficulty in caring for the comparatively few general medical and surgical and tuberculosis cases which came to us directly from the Army, but the situation in our neuropsychiatric hospitals was quite different. More than 50 percent of the men being discharged and transported to our hospitals for continued care were suffering from conditions diagnosed by the Army as psychiatric in nature.

Having served in my present capacity since my return from France in June of 1919, and having lived through the difficult days following the last war, I was extremely anxious that everything possible be done demobilization of our armed forces in 1919. In those days we were confronted with a deplorable shortage of personnel. My personal experiences in the early twenties was no doubt responsible for the attitude I assumed when our training army was mobilized. I was convinced we would be drawn into the European war and I hoped we might build an organization to meet our new responsibilities which would enable us to care for the veterans of the new war and their dependents with the utmost dispatch.

With this thought in mind, I discussed with the Administrator the possible effect of this increase in our armed forces on our hospital building program. This discussion resulted in a decision to await further developments before entering into a building program because at that time the number of patients in our general medical and surgical hospitals was decreasing. I have always believed in preparedness against any possible contingency.

Being convinced that we would enter the war, and being fearful that some of our hospitals in exposed positions on the coasts might be subjected to sudden enemy attack, I felt that plans should be prepared for the prompt evacuation of any such hospitals in the event of a national emergency. Therefore, 6 months prior to Pearl Harbor, I appointed a committee with instructions immediately to prepare detailed plans for the evacuation of any hospital in an exposed position on either coast. With the advent of Pearl Harbor, December 7, 1941, the situation materially changed. We were in the war. Wartime restrictions and limitations were placed on everything we did. It was indeed fortunate we had anticipated hostilities and had prepared plans for the evacuation of patients. These plans were immediately placed

into effect. Within 72 hours we had evacuated all transportable patients from our hospital and diagnostic center at Fort Miley, San Francisco. This hospital is located just above the Golden Gate and is in close proximity to several batteries of large caliber guns. Even if an enemy attack were directed at targets other than our hospital, the discharge of these guns would have shattered the window glass and made the facility untenable because of the heavy fogs which prevail in that locality.

Orders were also issued for the immediate removal of all patients from our 1,000-bed neuropsychiatric hospital at Los Angeles and all but the ambulant patients at our general medical and surgical hospital there. We also removed our blind and badly crippled domiciliary members from the barracks at that facility, leaving at that institution only those men who could care for themselves in case of an emergency.

The transfer of these 1,000 neuropsychiatric cases to inland hospitals presented quite a problem, but there again our previously prepared plans were found to be most effective. Doctors, nurses, attendants, and other personnel had to accompany the patients and we also had to transport beds, bedding, and other supplies with the patients as the receiving hospitals could supply only buildings in which to house them. Our field personnel responsible for these transfers to hospitals hundreds of miles away deserve the greatest possible credit for the humane and efficient manner in which these moves were made. It is difficult to transport one psychotic patient. I am glad to state that the 1,000 patients were moved to three different facilities hundreds of miles from Sawtelle without injury to one patient.

With the announcement of wartime restrictions on food, supplies of every character, equipment, and building materials, our difficulties of operation were greatly intensified. It became almost impossible to secure the supplies we needed for the operation of our field facilities and the equipment and materials necessary to build new ones. All of our requests for assistance in securing higher priorities were met with the statement that we were a civilian agency and as such we could expect no better treatment than any other civilian institution. Many meetings were held with boards, committees, and individuals employed by the Government agencies authorized to grant priorities. It was explained that the work we were doing in our hospitals and soldiers' homes was quite different from that done in civilian hospitals; that the patients in our hospitals were men who had worn the uniform in time of war and many of them were young boys of the present war who were discharged directly from Army and Navy hospitals into our institutions for continued care.

The reply of these gentlemen was invariably the same—namely, that we were a civilian institution and as such we could not secure higher priority than that granted other civilian institutions. We even pointed out actual cases of men who one day were patients in Army and Navy hospitals where they could have two or three cups of coffee with as much sugar as they desired one morning, and the next morning, as patients in veterans' hospitals they would receive only one cup of coffee with very little sugar added. I gave many other illustrations. I pointed out the difficulties and criticism which would ensue unless we could operate our hospitals on approximately the



same level as the Army and Navy institutions and I stated my belief that discharged soldiers and sailors sent directly to our hospitals from service hospitals would certainly not understand why they were able to get everything they needed and desired while in uniform and were limited practically to the necessities of life as soon as the uniform was removed.

I shall not impose upon your time by going into more detail as to the difficulties we encountered in securing supplies and equipment. Mr. R. C. Kidd, the Director of Supplies, and Col. L. H. Tripp, the Director of Construction, will go into these matters at greater length. I do want to emphasize, however, the fact that constant attempts were made to place the Veterans' Administration hospitals and homes on a parity with Army and Navy institutions without success, and that we were continually struggling with the War Production Board in an effort to secure priorities rated high enough to effect deliveries within a reasonable period of time. As a matter of fact, it was not until the passage of the Servicemen's Readjustment Act, signed by the President June 22, 1944, just one year ago, that the restrictions which operated against us were liberalized and we were given priorities comparable to or just under Army and Navy.

Mr. SCRIVNER. May I interrupt there for a moment, Mr. Chairman?

The CHAIRMAN. Mr. Scrivner.

Mr. SCRIVNER. Colonel, in view of the statement that you have just made of the recital of the difficulties which you encountered in obtaining priorities, a difficulty that was solved only with the enactment of the Readjustment Act of 1944—

Colonel IJAMS. Not completely solved, Mr. Scrivner.

Mr. SCRIVNER. Well, let us say, solved in part; did you at any time call that matter to the attention of this committee in the effort to obtain some legislation which might solve some of your problems for you?

Colonel IJAMS. I do not call things to the attention of this committee, Mr. Scrivner.

Mr. SCRIVNER. Well, did you suggest to anybody that it be done?

Colonel IJAMS. I suggested certain legislation which I felt would have enabled us to secure the priorities we required which would have enabled us to secure the personnel we needed and still need, and would have placed us in a much higher position as far as priorities in food-stuffs went.

Mr. SCRIVNER. To whom were those recommendations made?

Colonel IJAMS. To the Administrator, sir.

Mr. SCRIVNER. What action was taken on it?

Colonel IJAMS. Well, the Administrator did not agree with me, apparently. He did not do what I suggested be done.

Mr. SCRIVNER. Thank you.

The CHAIRMAN. The War Production Board, though, could have given you those priorities?

Colonel IJAMS. They could, sir.

The CHAIRMAN. And the War Production Board, of course, did not?

Colonel IJAMS. That is right, sir.

Mrs. ROGERS. What position do you hold in the Federal Board of Hospitalization?

Colonel IJAMS. Veterans' Administration representative.

Mrs. ROGERS. Who is the chairman of that Board?



Colonel IJAMS. General Hines.

Mrs. ROGERS. Does he have a vote?

Colonel IJAMS. No; he does not vote, Mrs. Rogers. The members of that board are the voting members. The chairman acts as chairman and does not vote.

Mrs. ROGERS. Has the Board of Hospitalization always followed your recommendation?

Colonel IJAMS. Not always, Mrs. Rogers. Let me make that clear. The Federal Board of Hospitalization has, I believe, followed the final recommendation which went to the board.

Mrs. ROGERS. You mean the final recommendation from General Hines?

Colonel IJAMS. From the Veterans' Administration which went to the board.

Mrs. ROGERS. Have you any NP specialists on that Board of Hospitalization? I think there used to be on it always a representative of Dr. White, from St. Elizabeths, and now my impression is you have no representative for the mentally sick on the board.

Colonel IJAMS. I do not know. I think General Kirk is an orthopedist, is he not?

Mrs. ROGERS. Yes.

Colonel IJAMS. I do not know what Dr. McIntyre and the other medical gentlemen are.

Mrs. ROGERS. Well, the board has always had that set-up.

Colonel IJAMS. Well, frankly, Mrs. Rogers, I have found the Federal Board of Hospitalization has been most generous in its support of any recommendation we made, whether for NP beds or general medical or TB, they do not care. They have been very fair and they have gone along, as far as I recall, with any recommendation which they have officially received from the Veterans' Administration.

Mrs. ROGERS. Did you take up with them these shortages of which you speak in supplies? And personnel, medical, and nursing personnel?

Colonel IJAMS. The Federal Board of Hospitalization has nothing to do with that.

Mrs. ROGERS. No, but have they talked it over, as doctors do?

Colonel IJAMS. That would have to be corrected within the Veterans' Administration.

Mrs. ROGERS. I know; I have talked it over with you and with the Administrator and also on the floor of Congress several times.

Colonel IJAMS. As a matter of fact, we have discussed our personnel matters informally a number of times—I mean they were not matters that were before the board because they have no jurisdiction. It is up to each department to secure its own priorities. Fortunately, the Army and Navy were in a very enviable position on priorities.

Mrs. ROGERS. Yes, but I find they have a great deal of interest in following the men through; they felt they could not spare their doctors, I understand.

Colonel IJAMS. I think I cover that later on in my statement.

Mrs. ROGERS. All right.

Mr. CUNNINGHAM. As a member of this committee, I never knew that there was any difficulty on the part of the Veterans' Administration in getting priority, until the Servicemen's Readjustment Act came before the committee as prepared by the Legion and the other

service organizations. This war had been on about 2 years at that time. I am just wondering why this committee did not know you were having those difficulties so we could aid you. Two years the war had been on.

Mr. SCRIVNER. It had been on 3 years then. It has been on 4 now.

Mr. CUNNINGHAM. No, it came to us a year ago last January.

Mr. ODOM. I am in a better position to answer that than Colonel Ijams, because I happen to know that General Hines was attempting to work that out with the Budget Bureau and the other administrative agencies concerned in the hope he would not have to bring it to the attention of the Congress.

I am sure he will clarify that when he testifies before the committee.

The CHAIRMAN. This omission could have been cured by Executive order or a ruling of the War Production Board, without an act of Congress.

Colonel IJAMS. Yes, sir; I had hoped that the President would become cognizant of it and issue the necessary orders.

Mr. CUNNINGHAM. Well, you feel that it is not sufficient now, even, under the Readjustment Act?

Colonel IJAMS. Mr. Cunningham, we are having difficulty every day. The situation has been greatly improved since the passage of the Servicemen's Readjustment Act, however.

Mr. CUNNINGHAM. What can we do now to amend the Readjustment Act so you would not have any difficulties? What is your suggestion on that?

Colonel IJAMS. Well, I have never advocated that we be placed on a parity with the War and Navy Departments. While there is a war on, I think they should have absolutely first priority in everything.

Mr. CUNNINGHAM. Then nothing will be done until the war is over?

Colonel IJAMS. No, I do not say that.

Mr. CUNNINGHAM. Well, you are second only to the Army and Navy now.

Colonel IJAMS. I have advocated from the start that we be second only to the Army and Navy, in time of war.

Mr. CUNNINGHAM. In time of war?

Colonel IJAMS. In time of war.

The CHAIRMAN. Let me call attention to the fact that we passed a bill the other day which went to the Senate and I understand the Senate passed it with an amendment, but left that provision of the bill intact.

Mr. ODOM. Well, we will now have priority equal to the highest of any given Government agency, and also will give us priority on space and services which the present law does not give. It also will give us the authority to lease, purchase, construct, or condemn buildings for any of the purposes of the Veterans' Administration spelled out as Mr. Scrivner stated.

The CHAIRMAN. It is my intention to ask unanimous consent to take that bill from the Speaker's table at the first opportunity and agree to the Senate amendments, because the amendments which the Senate put on it struck out some matters that can be inserted in other legislation.

Mr. ODOM. It eliminated the personnel proposition.

The CHAIRMAN. That is right and we can take care of that in other legislation; so, if nothing happens, we hope to have that situation cured within the next few days.

Colonel IJAMS. If I may complete the answer I was giving to Mr. Cunningham, it is my feeling now that the Army and Navy have practically completed their installations, that would be in conflict with anything we do. This gives us ample priority, or first priority, equal to the Army and Navy because they have completed their construction.

Mr. CUNNINGHAM. More than that, they are abandoning hospitals in this country now.

Colonel IJAMS. Oh, yes.

The CHAIRMAN. The truth of the business is the Army and Navy both probably will soon be in position to turn over some new hospitals to the Veterans' Administration.

Colonel IJAMS. No, Mr. Chairman, I have been in very close touch with General Kirk on that because I have been awfully anxious to avoid building anything if the Army and Navy had hospitals of the proper sort that would meet our needs. Now, one member of the committee the other day mentioned the fact that he did not think we should take over a lot of these hospitals away out in the woods some place. I might say that we have never had any intention of taking those over. They could not possibly serve us, because they were cantonment hospitals put out there in the training areas, where nobody lives, where there is plenty of room for the troops to maneuver. There are certain institutions which the Army and Navy built with the distinct understanding arrived at in the Federal Board of Hospitalization that they will be turned over to us after the war.

General Kirk has stated that we cannot look for those hospitals to be turned over to us within 2 years after the termination of the war because they have a big job to clean up after the shooting is all over.

Mr. DOMENGEAUX. Well, that would even be quicker than the program which is now under consideration because that will be completed in 3 years.

Colonel IJAMS. We have already taken over several institutions from the Army and they are in operation now. Also, we are in contact with the Army and have been for months about acquiring from them certain locations where they have, for instance, sewage-disposal plants, water plants, and all that sort of thing; even though the buildings might not be proper for our use, we can use those installations which have cost the taxpayers of this country millions of dollars and continue to use them after we build a proper hospital on that ground. We have close contact with both the Army and Navy on that.

Mrs. ROGERS. The Medical Corps would be in a very much stronger position, or the Medical Department, if it had a permanent corps, would it not, Colonel IJams? I know you have never favored it.

Colonel IJAMS. I am not so sure I agree with you on that, Mrs. Rogers.

Mrs. ROGERS. I know you have never favored it, but you would favor, would you not, a Department of Veterans' Affairs with a Cabinet head?

Colonel IJAMS. Mrs. Rogers. I think that if the head of our agency had been in close contact with the various Cabinet members during this war period and if he had told those men what our difficulties were



in regard to certain functions of their departments, I think the situation would have been greatly improved.

Mrs. ROGERS. Well, the Cabinet head naturally would have discussed those matters with his colleagues?

Colonel JAMS. That is right. I have no objection to making it a department. I think that the size and importance of the Veterans' Administration, the huge amount of taxpayers' money that we must necessarily spend, certainly would warrant some very serious consideration.

Mrs. ROGERS. And, in order to attract doctors and nurses you certainly must have a corps.

Colonel JAMS. I will be glad to discuss that in a minute, if I may, because I went out to Chicago last year on that very thing.

Mr. Chairman, if I may go on—

The CHAIRMAN. Proceed.

Colonel JAMS. To carry out its responsibilities in an expeditious and efficient manner the Veterans' Administration required the assistance of several other departments of the Government which control the supply and material situations in the country. Unfortunately, these agencies appeared to have little appreciation of the necessity for assisting the Veterans' Administration to secure all the supplies and equipment it would need to take care of the patients in its hospitals and homes and to promptly expand its facilities.

The statements I have just made should not be construed to imply that all agencies of the Government were deaf to our pleas. I am very glad to testify to the fact that certain officers of the United States Army and certain officials of the War Food Administration have assisted us materially in securing for our hospitals certain supplies such as butter, chickens, turkeys, meats, and so forth, which we could not procure in the open market as a civilian agency. There is no doubt that the splendid assistance and cooperation of General Hardig saves us from severe criticism when he made available to us many items of food which we could not otherwise procure. Mr. Kidd, the Director of Supplies, will cover this point more adequately in his statement.

During some months following Pearl Harbor the number of hospital cases in our general medical and surgical hospitals continued to decline but our tuberculosis and psychiatric patients increased materially. In fact, the neuropsychiatric cases represented and still represent more than 50 percent of the patients discharged from the Army and admitted directly to our hospitals for continued care. As an illustration, in July 1943, we received directly from the Army 1,693 patients. Of these, 996 were diagnosed as psychiatric cases. In November of that year there were 1,723 direct admissions from the Army of which 1,022 were psychiatric cases, and remember that a 1,000-bed psychiatric hospital is a big hospital, but we got that many in 1 month.

In March 1944 we admitted 2,172 cases directly from the Army, of which 1,409 were diagnosed as psychiatric cases. And in May 1945 we received 2,206 direct admissions of which 1,380 were psychiatric cases. I have not quoted all the monthly figures because I want to conserve your time.

The CHAIRMAN. What month was that?

Colonel IJAMS. Last month.

The CHAIRMAN. How many patients did you receive?

Colonel IJAMS. 2,203.

The CHAIRMAN. How many were neuropsychiatric?

Colonel IJAMS. Of those, 1,380 were psychiatric cases, but these figures indicate the trend of direct hospital admissions from the Army. The figures quoted do not include Navy admissions which were lower than the Army, nor do they include other World War II men previously discharged who came into our hospitals from civil life.

So that those figures, Mr. Chairman, do not represent all of our admissions. They are solely the direct admissions from the Army into our facilities for continued care.

Considering the fact that we had comparatively few vacant psychiatric beds when World War II began, it will be seen that we were immediately confronted with the most difficult task of providing beds for these men as quickly as possible so as to avoid the necessity of housing disabled veterans in jails, almshouses, and State and other institutions. Then, too, discharges from the Army and Navy for neuropsychiatric conditions came so quickly after mobilization that it was utterly impossible, because of the shortage of time, to erect sufficient beds to receive them. We were therefore forced to do the only thing we could to care for these men—that was to set up in our existing institutions overcapacity beds through the reduction of bed spacing in certain instances, the utilization of space previously used for day rooms. Simultaneously, we recommended the construction of psychiatric beds to meet our ever-expanding demands and in the early days of the war we devoted all of the talents of our very meager construction force to the production of neuropsychiatric beds. Later, beds for our tuberculous patients had to be increased and, more recently, we have included in our building programs not only neuropsychiatric beds and tuberculosis beds but beds for general medical and surgical cases also.

At this point I should like to emphasize the fact that the only thing that saved us from disaster as far as the psychiatric cases is concerned was the fact that the physicians in our psychiatric hospitals, through the use of modern psychiatric treatment, cured and sent to their homes a very high percentage of the neuropsychiatric cases placed in our hospitals by the armed forces.

While this transition was taking place: while we were making every effort to secure sufficiently high priorities to enable us to give service to World War II men, we were confronted also with a great shrinkage in our personnel. It was quite apparent we could not hope to retain in our service personnel in the lower-salaried brackets who could go into war industries and make more money in a week than we could pay them in a month. Also, we had in our service a large number of Reserve officers. These men were called to the colors. They included men from every service of the Veterans' Administration—lawyers, engineers, doctors, and administrative personnel. Also, we had in our service a large number of young men who thought it was their patriotic duty to serve in time of war and they volunteered.

It will be noted that our hospitals were not the only part of our organization losing personnel. As a matter of fact, we lost a much higher percentage of supply men and engineers than we did doctors

and we lost these men at a time when our load of work and responsibilities was increasing greatly and when it was extremely difficult, and in most cases impossible, to secure replacements. Every service of the Veterans' Administration suffered and is suffering today from a shortage of personnel. Not only were we required to continue the operation of previously authorized activities but new laws passed by Congress required us to assume additional responsibilities and to staff entirely new organizations to meet them.

Our insurance activity is a good example of that, sir.

This required personnel and space in which to house them.

I am sorry to say that with this situation confronting us, the Veterans' Administration was placed in class 5 for personnel priority, the lowest classification given any department of the Government. As a matter of fact, we were listed in the public press just below the Washington Zoo insofar as our personnel requirements were concerned—

The CHAIRMAN. By whom were you placed in that position?

Colonel JAMS. I do not know.

Mr. ODOM. The Bureau of the Budget.

Mr. CARNAHAN. You mean you were listed below the Zoo?

Colonel JAMS. In printing, in the paper, we were placed below the Washington Zoo.

It does not require much imagination to appreciate what will certainly happen when any organization is confronted with a vast increase in its activities and a great shrinkage in trained personnel available to transact business. This situation was clear to all of us and particularly so to the many employees of the Veterans' Administration who had confronted the same situation 25 years ago—the very situation which we hoped might be avoided.

We made every effort to fill our personnel vacancies through the Civil Service Commission. We employed women on work performed formerly only by men; we recruited in parts of the country far distant from war plants for service in the more congested areas, and we considered every plan suggested which might bring us personnel to fill the ever-increasing vacancies in our organization.

When it became apparent that we were still losing ground in spite of every effort on our part to recruit, I recommended what I considered to be a solution not only of our personnel problem but a plan which I expected would at the same time place us in a position of higher priorities for supplies, materials, and equipment and enable us to prepare plans for hospitals and secure their construction more expeditiously. It was my hope that the plan I suggested would enable us to retain in our service many of our employees who very properly sought to wear the uniform in time of war and at the same time would enable us to recruit personnel in the lower grades who could be carefully selected for their ability to perform such work as hospital and mess attendants. This plan contemplated the militarization of the Veterans' Administration for the duration of the war and 6 months thereafter. I felt that the militarization of our organization—and incidentally, I read in the paper this morning or yesterday that the Public Health Service had just been militarized—I felt that the militarization of our organization would enable us to maintain our numerical strength, that it would take us out of the category of "civil-



ian agency" which had made it impossible for us to secure all of the food and other essential supplies and materials, and would give us priority second only to the Army and Navy.

It was not my thought that the Veterans' Administration would retain in its services any man young and healthy enough to fight and the suggestion was made that all able-bodied young men be turned over to the Army and Navy for their use provided the armed services would in turn replace such individuals with properly trained persons who because of minor physical defects or age were disqualified for service with line troops. It will thus be seen that the plan suggested did not contemplate our making use of any men that the Army and Navy needed for the fighting forces. It would, however, have maintained our numerical strength and would have enabled us to have secured the additional personnel we so greatly needed in all the services of the Veterans' Administration. The adoption of this plan would, in my opinion, have saved months of arguments with various Government boards, bureaus, and individuals on the questions of rationing and priorities.

During the past 20 years or more we had built a hospital organization which became the largest group of hospitals in the world under single direction. We employed in those hospitals thousands of doctors, nurses, technicians, and other personnel who had participated in the First World War. These persons were first rate, thoroughly competent, and well trained individuals. They had an enviable pride in the part they had played in defense of their country and were determined to give a service to their disabled comrades second to none in this country. Veterans' hospitals were the envy of private practitioners. We developed among our staff members some of the outstanding physicians and surgeons in the country and there were made available to these men every type of equipment developed by science no matter how much that equipment cost. Our hospitals were visited by medical missions from many countries who expressed amazement at the splendid care America gave to her fighting men. Plans of our hospitals have been required by many foreign nations, and for many years our construction service has prepared all construction plans for St. Elizabeths Hospital in Washington, D. C.

Representatives of all the major veteran organizations have not only had access to our hospitals at all times, but many of them have occupied offices in our institutions which have been given to them free of charge by their Government. Thus these men have been in a position to observe the daily operation of our institutions and have been invited by the Administrator to offer any suggestions for their improvement.

No one denies that our hospitals are better constructed and perhaps much better equipped than the vast majority of the leading civilian institutions in America.

Then came World War II and a very natural desire on the part of some of our very best and most adequately trained personnel to serve with the armed forces. For a time we could make replacements but because of the ever-increasing demands of the Army and Navy for the best medical and nursing personnel in America to serve in their hospitals, we soon found we were confronted with a practically impossible situation in securing physicians of the high standards we

had always maintained. Fortunately, not all of our best operators left us for the armed services. Many appreciated the difficulties under which we labored and gave up the advantages of military life to remain in our service and carry on for the boys who were returning to our hospitals in need of continued care.

Those of you who have investigated the situation in municipal, county, State, and private hospitals have no doubt discovered as I have from personal observation that the standards of those institutions are not as high as they were prior to the war. During these war years I have had occasion to visit many of the leading private hospitals in America to visit relatives and friends who were patients in them. I have always asked about the service the patients were receiving and in every instance I found that the service in these institutions during the war could not compare with the standards maintained prior to the war. In making this statement I speak not only of the medical and nursing attention for which very high prices are charged in private hospitals, but also of the physical cleanliness of these institutions and the food served. The answer is, of course, that the personnel necessary to operate perfect institutions under ideal conditions is just not available today. I fear that many of the persons we shall require in veterans' hospitals will not be available for employment by us until many months after demobilization.

Please do not interpret any statement I have made to mean that I think all of the physicians and all of the nurses and all of the other personnel in veterans' facilities were perfect. This ideal situation will never exist on earth. But I do claim that the vast majority of our physicians were and are excellent men, graduates of class A medical colleges and imbued with the determination to give the best possible care and medical treatment to the patients whom they serve. Quite naturally, through the years we have employed some persons who did not live up to our expectations and we endeavored to eliminate these persons through the strict application of efficiency ratings.

I have never heard of any system which will prevent an incompetent or inept person from occasionally securing employment no matter what care is exercised in the selection of personnel. Fair-minded persons will admit that there are inept and incompetent persons in all institutions at the present time. All who patronize hotels, restaurants, stores, and railroads must agree with me. The only manner in which efficiency can be maintained is through careful selection, weeding out incompetents and replacing ineffectives. Under wartime conditions it is quite possible to weed out your ineffectives, but we have found it to be utterly impossible to replace these persons with more competent individuals.

In recent days certain distinguished physicians, members of our own medical advisory group, have made quite a few recommendations which I believe it proper to comment upon at this time.

Several have urged the use of dictating machines by our doctors. The facts are that we have bought thousands of dollars worth of dictating machines in past years and have urged our physicians to use them. Some are now in use but many have been used for a short time and then returned to storage. I am at a loss to know why the personnel of our own Medical Service in central office did not inform the medical advisory group of this fact as they had complete information on this subject.



These gentlemen have also suggested and urged the use of administrative personnel to relieve doctors of paper work. General Hines and I have been urging this very action upon the Medical Director and his assistants for many months. I have suggested the utilization of well-trained administrative personnel in the Medical Director's office and in the offices of the assistant medical directors to relieve them of certain correspondence which does not require medical knowledge for replies. We have also urged the utilization of legally trained personnel to handle all investigation work in our field facilities, thus relieving the doctors of performing duties for which they are not trained so that they can spend more of their time on clinical medicine. These recommendations have also met with the disapproval of our medical men. As these facts were fully known to the Medical Director and his assistants it is most unfortunate they did not give the medical advisory group full information on this subject.

Some of our medical advisers have recommended more supervision. This is a matter within the jurisdiction of the Medical Director who has full authority to require such supervision as he may determine to be suitable and proper. One of the advisers also stated he felt that more frequent meetings of the medical advisory group should be held. This recommendation has been made before and has been discussed with the Medical Director. This too is a matter within the jurisdiction of the Medical Director who has but to recommend a meeting of the medical advisory group and that meeting will be approved by the Administrator as all such recommendations have been approved in the past.

In discussing the medical advisory group, I believe it would be well at this point to bring out the fact which appears to have been forgotten in the maze of time, that the original medical council was first organized upon my recommendation made many years ago and that at the time the suggestion was first made the then Medical Director opposed the establishment of such a council because he stated it would be impossible for us to secure outstanding medical men who would devote their time to this duty. I expressed my disagreement with his opinion and stated I felt that the outstanding medical men of America would be only too glad to devote their talents in an advisory capacity to the great medical and hospital organization we then contemplated building. The then Medical Director finally concurred in my recommendations and the council was established.

My original recommendation contemplated the establishment of a group of the finest medical men in the country in the various specialties who would visit our hospitals in the field, observe the clinical medicine practiced in them, and then meet in Washington and criticize constructively the treatment we were giving. I stated that through this means we could always maintain the clinical medicine practiced in our hospitals at the very highest level and be certain that the medicine our doctors practiced was the latest thing known to medical science.

I feel it would also be well to remind the members of this committee, the public, and the members of our medical advisory group, that the diagnostic centers which we operate in several parts of the country were also brought into being through my recommendation made many years ago. This recommendation was also disapproved by the then



Medical Director who stated that the creation of diagnostic centers would be an admission that our other hospitals were not as good as they should be. I pointed out the fact that in private practice when our family physician met a medical problem upon which he desired consultation he did not hesitate to call in consultants whom he considered to be better equipped to make a diagnosis in the particular case than he was as a general practitioner.

I explained that this was the very thing I was recommending in the establishment of our diagnostic centers; that it was not my thought that all cases would go to these centers but only those problem cases where we were having difficulty in diagnosing the cause of the trouble.

Inasmuch as the distinguished physician for whom I have the highest regard has testified before this committee that the Medical Service of the Veterans' Administration will be improved only when the Medical Director of the Veterans' Administration is raised from a subsidiary position to report directly to the Administrator, I hope you will allow me to call attention to the organization of the Army, Navy, and Public Health Service medical departments. It cannot be denied that these agencies occupy a most important place in the structure of medical organizations within the United States Government. I merely wish to point out that the surgeons general of the Army, the Navy, and the Public Health Service are not responsible directly to the heads of their departments but report through administrative channels set up for this purpose. The Surgeon General of the Army reports to the commanding general of the Army Service Forces who acts under the direction of the Under Secretary of War who in turn reports to the Secretary of War. Under this organization the Surgeon General occupies a similar position to that of the Chief of Engineers, the Quartermaster General, the Chief of Ordnance, the Adjutant General, the Judge Advocate General, and so forth, all of whom report to the Commanding General of the Army Service Forces.

It would therefore appear that the argument used to place the Medical Director of the Veterans' Administration immediately under the Administrator in order that there might be an improvement in our Medical Service might likewise be applied and should be applied, if we are going to be consistent, to the medical departments of the Army, the Navy, and the Public Health Service.

I wish it known to the members of this committee that I have no objection whatever to an organization which will require the Administrator to handle all matters pertaining to the Medical and Hospital Service of the Veterans' Administration. I so expressed myself to General Hines both verbally and in writing on several occasions. However, I call attention to the fact that this change would throw an additional heavy burden of administrative duties upon the shoulders of the Administrator and would require him personally to coordinate the work of the Medical Service with many other services. Also, such a change should logically be followed by having the directors of all other major services such as Insurance, Pensions, Supply, Construction, Rehabilitation, Loans, and Finance also report directly to the Administrator. Obviously it would be quite impossible for any one human being to assume such a burden of duties.

Inquiry of the present Medical Director will, I am certain, produce a statement from him that he has never been denied access to the

Administrator of Veterans' Affairs, and, further, on hundreds of occasions he has been requested by me to see the Administrator and discuss his problems without anyone else being present.

I feel that the statements of several doctors are based upon a most unfortunate lack of knowledge of the true situation which exists and has always existed in the Veterans' Administration. As I have stated before, our Medical Director is the supreme medical authority and I have never known of anyone who has even suggested to him how clinical medicine should be practiced or how patients should be treated in Veterans' Administration hospitals. I am making this statement solely for the purpose of bringing out the truth of the situation so that this committee in its deliberations may have the actual facts before them.

I dislike to inject these personal matters into a report of this character and I would not do so except that I feel certain statements have been made to this committee in all good faith but which show that the authors of those statements do not have the complete knowledge of the evolution, so to speak, of the great medical and hospital organization which the Veterans' Administration has built over the years. I only wish that through the years the medical council had continued to devote its entire time to the purpose for which it was organized—namely, inspection of our hospitals and constructive criticism of the clinical medicine practiced therein. I hope in future they will visit the hospitals and constructively criticize our work because it is only through this means that the high standards of medical practice which we have tried to establish and maintain can be achieved.

Some of the witnesses in recent days testified that our doctors are as well trained and conscientious as the doctors in civilian institutions. In the vast majority of cases this has been my reaction. I want here and now to express my respect for and confidence in the hundreds of fine medical men in our service who are laboring so hard to keep our organization together in functioning for the benefit of our patients under the most trying circumstances. I should like to point out one thing that I have always discussed with young, well-trained medical officers who wanted to come with this organization, and that is that the advancement in the service of the Veterans' Administration for a young medical man is far quicker than it is in any other organization in America. This is true because of our greatly expanding activities.

Adverse criticism of veterans' hospitals in recent months has had a most unfortunate effect upon a great many of our citizens, particularly so upon the parents and wives of our disabled defenders. I regret to say that this criticism has also had a serious effect upon the morale of thousands of our faithful, hard-working, and competent employees. It would be not only foolish but untrue to deny that our service has been affected by the loss of trained and competent personnel to the armed forces. At the same time I believe that the loyal and faithful men and women who remain with us should be given full credit and praise for the manner in which they have assumed added burdens and attempted to keep the machine going in spite of the disastrous effect of having lost so many of our personnel to the Army and Navy.

In time of war, soldiers and sailors who do the best they can under adverse circumstances, are praised and sometimes decorated. Fortunately for the morale of our employees, since this unfavorable publicity commenced, we have received hundreds of communications from



men who have been in our hospitals many times and who know from personal experience the high standards of service we have always tried to maintain. These letters, coming from those who are most competent to judge because they themselves have profited from our service, are worth more to our personnel than any decoration they might receive. These letters, entirely unsolicited, have come from the hearts of grateful men who have served their country in time of war and who marvel at the fact that we are able to give as good service as we do today considering the many difficulties under which we operate.

Of course if the Axis had prevailed in this war and had conquered America, we would have nothing to worry about insofar as our hospitals are concerned. Those countries operate on the theory that all physically and mentally disabled should be destroyed. We in America and the citizens of all other decent civilized nations have always cared for those who have defended us in time of war. We have done the best we could with the tools available to us to do the job.

Mistakes have been made and unfortunate incidents have been discovered, but when these things have come to light we have acted quickly to discipline or prosecute those responsible for the conditions reported. We shall continue to use every means at our disposal to rid our service of incompetents and of those who do not fully comply with the instructions to give intelligent, conscientious, and sympathetic service to our disabled men and women.

Within a comparatively short time we hope to bring this Second World War to a successful termination. When demobilization begins, and not until then, we shall be in a position to secure a higher type of personnel for all of the activities of the vast organization which is known as the Veterans' Administration. And again at this point I would like to reemphasize a statement I made early in this report on the great number of activities of the Veterans' Administration which require competent, trained personnel to enable us to give the service which the American people expect us to give to our disabled veterans. I call your attention to the fact that while hospitalization is of the utmost importance to disabled veterans in our hospitals, it is not the all important interest to the widows and orphans of the men who made the supreme sacrifice. What they are interested in is prompt adjudication of their insurance and pension claims, and I say again that we have as great a legal and moral obligation to adjudicate these claims quickly and sympathetically as we do to operate our hospitals in an efficient manner. Therefore it is absolutely essential that the entire Veterans' Administration be given competent personnel immediately and adequate space in which to house them.

When demobilization time arrives there will be available to us thousands of young men and young women, veterans of the Second World War—lawyers, doctors, engineers, nurses, technicians, clerks, and stenographers—who will be willing and anxious to come into the Veterans' Administration for a lifetime career of service to their disabled comrades, just as thousands of us came into the service just after demobilization in 1919. Many of the young doctors, engineers, and attorneys now serving in the Army and Navy will find themselves without an established practice in their civilian communities and will be glad for an opportunity to serve through the Veterans' Administration their disabled comrades of the battlefields of Europe and Asia. I



have no fear as to the availability of a sufficient number of well-trained, competent personnel for our services after demobilization of the armed forces. What worries me and what has worried me for months and even years is the lack of trained personnel available currently to meet the problems of demobilization.

Even now we are doing our utmost to bring into our service veterans discharged from the present conflict and to place them in positions of responsibility. When the real demobilization begins, we shall no doubt be able to select discharged men of all types and of all educational backgrounds, many of whom have received specialized training while in the service. Until that day arrives, we, like all other organizations in America, shall be forced to do the best we can with the tools available to us.

In conclusion, I can only say that based upon my personal knowledge of the situation, and my observation of other institutions of healing, if I were unfortunate enough to require hospitalization, even under wartime conditions, I would rather be a patient in a veterans' hospital than in any other hospital in the world.

The CHAIRMAN. Thank you very much, Colonel.

Are there any questions?

Mrs. ROGERS. Yes, Mr. Chairman. Colonel Ijams, how do you explain the fact that the Department of Agriculture and for want of another name, let us call them the alphabetical agencies, had no difficulty comparatively in securing personnel and the Veterans' Administration did have that difficulty?

Colonel IJAMS. I am afraid I cannot explain that.

Mrs. ROGERS. Is that because the Veterans' Administration is the lowest-paid department in the United States Government?

Colonel IJAMS. I do not really know that there is any difference in pay. I have never had occasion to look into that at all.

Mrs. ROGERS. Well, you have been studying the whole question, Colonel Ijams. I should think that would be one of the first things—

Colonel IJAMS. That is not my job at all, Mrs. Rogers; I have a good many other things to do. That is the job of our personnel officer, to see—

Mrs. ROGERS. Yes; but do they not have council meetings where you and the personnel officer and the insurance officer meet?

Colonel IJAMS. No; I do not recall ever having been in a meeting where we discussed comparative salaries between departments.

Mrs. ROGERS. In your own office you have had requests for raises of salaries?

Colonel IJAMS. Oh, my, yes.

Mrs. ROGERS. Does that fit into your picture?

Colonel IJAMS. Yes, indeed; where they come in my own department. I have had many, many a request for raises.

Mrs. ROGERS. But they are low in your own department, are they not?

Colonel IJAMS. Well, I would have to know what the others were to say that ours were lower.

Mrs. ROGERS. You made no effort to find out what the comparison was?

The CHAIRMAN. Let me say to the committee that we are sitting now in violation of the Speaker's orders. We would like to speed this matter up as much as possible and conclude with Colonel Ijams.

Mrs. ROGERS. Why did you not try to secure the formation of a Medical Corps in order to attract more highly skilled doctors, nurses, and assistants, Colonel Ijams?

Colonel IJAMS. Mrs. Rogers, I have tried to bring out that the recommendations I made, in 1941 or early 1942, were made for that very purpose, and to maintain our numerical strength, which was shrinking very fast through the inroads of war industries and men going into the service, to treat all of our personnel alike and to secure for us benefits insofar as priorities were concerned.

I might say that had we been successful, we would have taken in the attendant class certain personnel who might have been rated IV-F by the Army, but a man with a punctured drum can do as good a job in a clerical job, or even as a hospital attendant, with us, as a perfectly able-bodied man and still that man would not have been taken by the Army or Navy. It was our thought that the entire Veterans' Administration should have been militarized because we felt it would be very beneficial from every angle and I was very much interested, yesterday, to read that, even at this late date, the Public Health Service has been militarized.

Mrs. ROGERS. That authorization was given, as you know, some time ago; I think it was last summer.

Colonel IJAMS. Yes.

Mrs. ROGERS. But a Medical Corps would have helped the situation insofar as your sick and disabled are concerned and that is the primary duty of all of us.

Colonel IJAMS. Mrs. Rogers—a Medical Corps at what time?

Mrs. ROGERS. From the very beginning of our entrance into the war.

Colonel IJAMS. I would go back further than that even.

Mrs. ROGERS. Oh, yes; I know; but I mean in this emergency.

Colonel IJAMS. Oh, in the emergency, yes; but on the other hand, Mrs. Rogers, let me call your attention to this: There is no doubt a Medical Corps would have helped to retain some doctors, but during this war were required to build an entire new insurance business from the ground up, the National Service Life Insurance. Today that company, if we can call it that, is practically as large as the three or four hundred commercial insurance companies in America. There are many insurance companies who have a hundred or more executives receiving not less than \$10,000 a year—and you know some of those salaries run to the sky—in this huge business of ours, we have not one man receiving a salary of \$10,000.

Mrs. ROGERS. No; but I am on the Medical Corps at the moment, Colonel.

Colonel IJAMS. Well, if I might continue, my thought was this: Had we militarized the Veterans' Administration, we could have gotten insurance executives who would not come in here to work on a Government salary but who would have come to us and taken jobs of great responsibility to assist us in building and maintaining this big insurance company if we could have offered them commissions. Now, the same thing is true in our other important activities. I believe in treating all of these agencies alike, Mrs. Rogers.

Mrs. ROGERS. Yes; but if you had had a Medical Corps in 1925, you would have had your doctors and kept them.

Colonel IJAMS. But that would not have helped us on the insurance, on the claims, and a thousand and one other things.

Mrs. ROGERS. But I have been discussing that for a good many years also, and I think that the change of General Bradley for General Hines will not bring about a solution unless General Bradley be given great power.

Colonel IJAMS. I agree with you. He should have complete power to do whatever he likes.

Mr. CUNNINGHAM. He probably will.

Mr. SCRIVNER. Well, doesn't he have it?

Colonel IJAMS. I hope so.

Mrs. ROGERS. I do not think he will have it unless he is—throughout the years—I think the Director should have power, too.

Colonel IJAMS. Oh, yes. Well, I do not know of any lack of authority given to any director or administrator or anyone that I have worked under. Of course, there are a great many policy matters that come up that have been discussed with the President because they must be coordinated with the objectives and policies of the administration in power.

Mrs. ROGERS. Well, then, these matters have not been taken up with the President, you believe?

Colonel IJAMS. No; I did not say that.

Mrs. ROGERS. Well, I mean that is the obvious conclusion?

Colonel IJAMS. In the many years I have been there, there have been many problems which should and probably have been taken up with the Executive. I do not know what matters have been taken up because I have not been present.

The CHAIRMAN. Do you have any questions, Mr. Cunningham?

Mr. CUNNINGHAM. No questions.

The CHAIRMAN. Mr. Scrivner?

Mr. SCRIVNER. I have just a couple of questions for clarification.

You were present when Colonel Tripp testified and in that statement he said that he had prepared the suggestion and the need for an early start on hospital plans in January of 1942. That was forwarded to you, and you in turn forwarded that to General Hines, February 4, 1942. What action was taken by the Administrator on the plans which you forwarded to him?

Colonel IJAMS. I sent that memorandum to the Administrator on February 4; on February 17, I sent Colonel Tripp a memorandum telling him that it was desired for him to start the preparation of plans on the projects that had been recommended as soon as possible, even if the job did require some time because of the shortage of personnel for this work.

It was desired that the plans and specifications of buildings be ready so that we could submit them for bids promptly after approval was obtained for the new construction which had been proposed, but I might say, Mr. Scrivner, that long before that, I had taken action toward—

Mr. SCRIVNER. Well, what action did Colonel Tripp take upon that memorandum you sent him?

Colonel IJAMS. The director of construction replied, in memorandum of February 21, regarding the preparation of plans for new buildings and suggested that plans be prepared not only for those projects for which funds were then available but also those that were being withheld from the market because of the drain on available man-



power as the result of the war building; but to include some of the projects which were listed in connection with the acceleration of the 10-year construction program.

Mr. SCRIVNER. Well, was that done? Were the plans drafted?

Colonel IJAMS. Well, now, wait, I have not all this in mind. This is some time ago. This program—on February 27, that had been submitted was discussed with the Administrator and he expressed approval of the procedure proposed. However, he stated he did not think it proper to employ additional personnel until the Federal Board of Hospitalization had decided on what action should be taken in connection with the 10-year program.

Then, on April 20, 1942, a memorandum was addressed to the Chairman of the Federal Board of Hospitalization forwarding a list of 10 different advertising dates which would apply—

Mr. SCRIVNER. Can we skip down and find out actually what was done, if anything at all? Was there anything done? As I got it from Colonel Tripp, he made the suggestion, and yet that is where it seemed to stop, and the plans were not put in detailed blueprints at all?

Colonel IJAMS. I am told that that went to our budget office and they commented unfavorably on it.

Mr. SCRIVNER. In other words, it has been—

Colonel IJAMS. It was not until August that we brought it up again. We had recommended 12,000 NP beds on February 4, 1942, and then in August, that program was approved for submission to the Federal Board for 800 beds.

Mr. SCRIVNER. Still the blueprints were not drawn. In other words, it is another demonstration of a lot of the discussion and little action?

Colonel IJAMS. May I say something there about the initial action that was taken which I think will clear up your ideas?

When the training Army was mobilized, prior to Pearl Harbor, I discussed with the Administrator the effect of this mobilization upon our hospital requirements. It was decided to do nothing at that time because the number of our general medical and surgical patients were decreasing.

Mr. SCRIVNER. I remember you saying that.

Colonel IJAMS. On December 8, 1941, the day following Pearl Harbor, I contacted the Administrator and recommended that sufficient funds be authorized for the employment of a force of architects and engineers—and remember, Colonel Tripp's organization had been cut down to a maintenance and operation group—to immediately begin preparation of plans and specifications for one additional building at every existing facility. No action was taken at that time, but at a meeting of the Federal Board of Hospitalization, December 24, of that year, Christmas Eve, 1941, I again brought up the subject and discussed the desirability of profiting from experience in the past war by preparing plans and specifications for at least one additional building at every existing facility and stated that it was not my thought that all the buildings should be erected at once, but I wished to prepare the plans for them before the pressure became acute and while manpower was available and for this work.

My recommendation was voted down by the Federal Board of Hospitalization.

I might say that was not a matter for the Federal Board to act on, but I brought it up in the hopes that they would back me up.

Mr. SCRIVNER. Now, while I might not agree with the necessity or advisability of militarizing the Veterans' Administration, because, after all, it is a civilian agency—

Colonel IJAMS. That was for the duration.

Mr. SCRIVNER. I know, even for the duration, in my opinion, it has not worked out any too well as matters now stand, and you stated that early in 1941 or late in 1941 and early in 1942, you did propose this plan? Now, to whom did you make the proposal?

Colonel IJAMS. I made it to the Administrator.

Mr. SCRIVNER. What action was taken on that?

Colonel IJAMS. All recommendations I make are to the Administrator.

Mr. SCRIVNER. What action was taken on that recommendation?

Colonel IJAMS. Well, I presume General Hines disagreed with the idea, because nothing was done.

Mr. SCRIVNER. That is all.

The CHAIRMAN. Thank you very much, Colonel Ijams.

Mr. ODOM. Mr. Chairman, I would like, if I may, to be permitted to have the record straight on that question of paying lower salaries than other governmental agencies.

Outside of some special acts that were passed to give certain agencies authority to employ personnel without Civil Service status, my understanding is that all departmental service in the District of Columbia is classified by the Civil Service Commission, including the Veterans' Administration. Is that not so, Colonel Ijams?

Colonel IJAMS. That is correct.

Mr. ODOM. So that if there is any discrepancy between classifications in the Veterans' Administration and other governmental agencies, it is not the fault of the Veterans' Administration.

Mr. SCRIVNER. That is in Washington, D. C.?

Mr. ODOM. That is what I am speaking of.

Mr. SCRIVNER. I understand that outside of Washington, D. C., the Veterans' Administrator has a great deal of power in classification ratings.

Mr. ODOM. That has been stated, Mr. Chairman; and as a lawyer, I disagree. It remains to be seen whether the Comptroller General will agree with it.

The CHAIRMAN. We will hear General Hines first thing Tuesday morning and he will no doubt discuss those phases of the Veterans' Administration.

Mrs. ROGERS. When are you going to hear General Kirk, Mr. Chairman?

The CHAIRMAN. I am going to adjourn right now to 10 o'clock Tuesday morning and the next witness will be General Hines, Administrator of the Veterans' Administration.

(Whereupon, at 4:20 p. m., June 29, 1945, the committee adjourned to reconvene Tuesday, July 3, 1945, at 10 a. m.)

INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH  
A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY  
OF THE ADMINISTRATION AND OPERATION OF  
VETERANS' ADMINISTRATION FACILITIES

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HEARINGS  
BEFORE THE  
COMMITTEE ON WORLD WAR VETERANS'  
LEGISLATION  
HOUSE OF REPRESENTATIVES  
SEVENTY-NINTH CONGRESS

FIRST SESSION

PURSUANT TO

**H. Res. 192**

(79th Congress, 1st Session)

A RESOLUTION TO DIRECT THE COMMITTEE ON  
WORLD WAR VETERANS' LEGISLATION TO  
INVESTIGATE THE VETERANS'  
ADMINISTRATION

---

**PART 6**

JULY 3, 1945

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Printed for the use of the Committee on World War Veterans' Legislation



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SEVENTY-NINTH CONGRESS

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# INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY OF THE ADMINISTRATION AND OPERA- TION OF VETERANS' ADMINISTRATION FACILITIES

TUESDAY, JULY 3, 1945

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WORLD WAR VETERANS' LEGISLATION,  
*Washington, D. C.*

The committee met at 10 a. m., Hon. John E. Rankin (chairman) presiding.

The CHAIRMAN. The committee will come to order. General Hines, will you come around?

## STATEMENT OF GEN. FRANK T. HINES, ADMINISTRATOR OF VETERANS AFFAIRS

(The General was duly sworn.)

General HINES. Mr. Chairman, Mrs. Rogers, and gentlemen of the committee, I appreciate the opportunity of coming down here again. There is much that I probably could say to the committee, but I am satisfied you have had the opportunity of having the hospitals of the Veterans' Administration appraised, not only by the servicemen themselves, and Members of Congress, but you have had before you some outstanding doctors that I am sure have given you their independent opinion frankly.

It has been my endeavor to get before this committee all of the facts that bear upon the investigation. I have had, of course, no opportunity to hear all of the evidence presented, but I am hopeful the committee will grant me the right, when the testimony has been printed, to place a statement in the record covering such points as may be desirable to have comment on.

The CHAIRMAN. Without objection that is ordered now.

General HINES. One of the most important items that has grown out of the testimony before the committee, and the questions asked by the members of the committee, has been based upon the question of the program of hospital construction and its bearing, of course, upon the conditions which have been referred to as overcrowding. I would like to say that we are willing to admit that the hospitals, in some instances, are crowded, but we do not feel that they are overcrowded.

I think it is important that the committee know what steps have been taken in connection with this program of construction, first, and in the matter of location of hospitals.

I might say that a number of hospitals, of course, were located long before the Federal Board of Hospitalization had anything to do with it. I have a chart here that lists all of the hospitals of the Veterans' Administration, giving the dates of their opening, and the closing dates of some of the old ones, from the very beginning. I would like to have that made available to the committee; I am not sure you wish to put it in the record.

I am dwelling upon that primarily for one purpose: It has been stated that some of our hospitals are isolated. That is true. I can name two that are too much isolated; one at Dawson Springs, Ky., and one at Fort Bayard, N. Mex. And there are others that are distances out from the centers, but those were selected and taken over at a time of emergency. Please remember that when we came out of the last war that hospital facilities, except those in the Army and Navy and Public Health did not exist. We had to use contract facilities; they had to take over from the Army and Navy as rapidly as they could. We have no comparison in that situation with that which exists today.

The Federal Board, and also the Veterans' Administration believes in medical centers. Long ago we established diagnostic centers. The location of those will show you they are located near large medical centers—Washington, D. C., where on the staff we have representatives from Johns Hopkins. Men outstanding in medicine and surgery come all the way from Boston. We have a diagnostic center at Chicago that you have heard something about recently, and I think probably outstanding work in development and research work is carried on at that point. We believe in the utilization of consultants, we believe in taking advantage of medical talent wherever it can be found. I would like to point out, however, that from the very beginning I have never felt that the veterans in our hospitals should be used for any experimentation whatever. A remedy or a new method had to be definitely proven before permission was granted to use such method.

I still believe in that system; I think it is sound; I think it has been proven to be sound.

On the question of location of hospitals, that has an important bearing on the veterans themselves, after they are placed. Of course, you could not possibly place all of the hospitals now, or that we will have, near the large medical centers. It is possible, however, and recently one was located on the same reservation near Pittsburg where there is a large medical school. I don't consider that the location of the diagnostic center at Hines, Ill., is out of the way, although it was proposed there that we put the hospital on the grounds of the university.

Mr. ALLEN. You are locating around the large medical centers.

General HINES. That is right, in that vicinity. We have always felt that for the recovery of the patient that it was important, if he was to be retained in a hospital any length of time, that he should be located where his family and his friends could pay him periodic visits. For that reason the Federal Board, and our thinking in the Veterans' Administration has led to the conclusion that it is better to have these hospitals near the centers of veteran population. I mean the general run of hospitals. We have also felt that the neuropsychiatric hospitals should be out in the country, convenient to good transportation, but out where they are not so closely associated with large communities.

They do better, and I am sure the outstanding psychiatrists who have testified here will confirm me in that view.

But in the location of the new ones now under consideration by the Federal Board we have felt wherever it was possible to divide the distance between existing hospitals of the same type that we should endeavor to do that.

Yesterday before the Federal Board of Hospitalization we had up a program involving the expenditure of about \$180,000,000 and a large number of beds, and in the study of that program I am sure that every member of that Board was impressed with the fact that the prediction as to the number of beds since Congress passed the law to take in non-service-connected cases of World War II had been very close.

This program was based upon the request from the Veterans' Administration for 15,333 general and surgical beds, 8,137 NP beds, 2,413 TB beds, a total of 25,843 additional beds. The Federal Board's staff in its study increased the number of general and surgical beds to 17,385, the NP beds to 8,940; and reduced the TB beds to 2,150.

That study of theirs was agreed upon for the simple reason that we felt that this program, which is constantly under revision, could be reviewed and if we found a load different from what our observations are now, it could be changed.

This proposed program will increase the present hospital facilities of the Veterans' Administration from 98,577 beds to 130,432 beds; its domiciliary facilities from 15,711 to 16,600.

The CHAIRMAN. What was that increase, that last?

General HINES. Up to 16,600; from 15,711 to 16,600.

I might explain there, Mr. Chairman, that looks like a small increase of domiciliary beds, but the fact remains that many of the facilities that will come from the Army that are well located for such purpose will create good opportunity for utilization for domiciliary cases where they cannot be used for hospital cases.

That makes a grand total of 147,052 beds.

Mrs. ROGERS. I wonder if we could have the location of the beds.

General HINES. The Federal Board has not prepared other than the release that we made, but I will say that any member of the committee that wishes this schedule, I will be glad to give it, although I think most of the members received the release we originally made.

Mrs. ROGERS. Have you copies there?

General HINES. I only have one, but I will see that you get it.

Mrs. ROGERS. How many beds for women?

General HINES. A large number of beds for women. We are arranging for a number of beds for women in connection with our new hospitals. I will reach that.

Mrs. ROGERS. I will have to go to the White House in a little while.

General HINES. Colonel Tripp, can you get me the data on women?

In this estimate the comparisons between the estimates heretofore submitted and the actual load as of April 1945, are these: General medical and surgical, the actual beds required, 20,323. That means we actually needed those beds; NP, 43,878; TB, 7,065, making a total of 71,266.

The estimates compare very closely. Our estimate of the number of beds was 21,300, general and surgical; 44,100 NP, 8,100 TB, making a total of 73,500.

I shall also place in the record, Mr. Chairman, a statement which will show the amount of money available, starting with the fiscal year



1939 and closing with the fiscal year 1945. This statement shows the number of beds available, those contemplated building, where they were to be built and where they were built, the dates the awards were made.

It will show this clearly, Mr. Chairman, that at no time has there been a lack of funds available, that the Congress has appropriated money as rapidly as it has been needed, that balances have been sufficient at all times to effect the programs that were in contemplation.

The CHAIRMAN. That statement may be made a part of the record. (The statement referred to is as follows:)

*Fiscal year 1939*

Unobligated balance available for construction June 30, 1938..... \$3,957,876.43  
Appropriated Mar. 16, 1939..... 4,015,000.00

	TB	Psy- chotic	Other NP	Gen- eral	Total	Domi- ciliary	Grand total
Beds available June 30, 1938:							
Veterans' Administration facilities.....	5,197	27,999	2,312	16,483	51,991	16,798	68,789
Other Government.....	332	98	44	2,047	2,521	-----	2,521
Total.....	5,529	28,097	2,356	18,530	54,512	16,798	71,310
Work in progress June 30, 1938.....	157	1,856	-----	1,872	3,885	-----	3,885
Beneficiaries remaining June 30, 1938:							
Veterans' Administration facilities.....	4,573	26,459	2,256	13,967	47,255	14,106	61,361
Other Government.....	332	98	44	2,047	2,521	-----	2,521
Total.....	4,905	26,557	2,300	16,014	49,776	14,106	63,882
Beds unoccupied June 30, 1938.....	624	1,540	56	2,516	4,736	2,692	7,428

PROJECTS NOT UNDER CONTRACT JUNE 30, 1938 FOR WHICH FUNDS WERE AVAILABLE

Location	Beds <sup>1</sup>	Date of award
Amarillo, Tex.....	150 general.....	Oct. 29, 1938
Batavia, N. Y.....	35 general.....	-----
Bath, N. Y.....	395 domiciliary.....	Aug. 10, 1938
Do.....	140 domiciliary.....	Aug. —, 1938
Bay Pines, Fla.....	392 domiciliary.....	Feb. 10, 1939
Bedford, Mass.....	368 neuropsychiatric.....	July 23, 1938
Bronx, N. Y.....	600 general.....	Oct. 29, 1938
Camp Custer, Mich.....	524 neuropsychiatric.....	July 27, 1938
Cheyenne, Wyo.....	45 general.....	May 9, 1939
Chillicothe, Ohio.....	358 neuropsychiatric.....	Aug. 5, 1938
Cleveland, Ohio.....	250 general.....	Dec. 30, 1938
Dallas, Tex.....	do.....	Dec. 23, 1938
Dayton, Ohio.....	828 domiciliary.....	July 13, 1938
Fargo, N. Dak.....	77 general.....	Aug. 13, 1938
Fayetteville, N. C.....	300 general.....	Mar. 31, 1939
Huntington, W. Va.....	132 general.....	Aug. 3, 1938
Indianapolis, Ind.....	170 general.....	July 27, 1938
Knoxville, Iowa.....	368 neuropsychiatric.....	July 23, 1938
Lincoln, Nebr.....	48 general.....	Aug. 10, 1938
Los Angeles, Calif.....	53 domiciliary.....	July 18, 1938
Do.....	376 neuropsychiatric.....	Aug. —, 1938
Lyons, N. J.....	358 neuropsychiatric.....	July 23, 1938
Marion, Ind.....	134 neuropsychiatric.....	-----
Montgomery, Ala.....	250 general.....	June 14, 1939
Murfreesboro, Tenn.....	390 neuropsychiatric.....	Aug. 9, 1938
Muskogee, Okla.....	35 general.....	Oct. —, 1938
North Chicago, Ill.....	372 neuropsychiatric.....	Aug. 3, 1938
Palo Alto, Calif.....	147 neuropsychiatric.....	Aug. 13, 1938
Pittsburgh, Pa.....	266 general.....	Sept. 28, 1938
Salt Lake City, Utah.....	20 general.....	May —, 1939
Tuscaloosa, Ala.....	43 neuropsychiatric.....	June —, 1940
Do.....	183 neuropsychiatric.....	Aug. 13, 1938
Waco, Tex.....	185 neuropsychiatric.....	July 20, 1938
Wadsworth, Kans.....	350 domiciliary.....	Dec. 28, 1938
White River Junction, Vt.....	77 general.....	Aug. 13, 1938
Wichita, Kans.....	do.....	Aug. 10, 1938

<sup>1</sup> Total beds, 8,751.

*Fiscal year 1939—Continued*

## PROJECTS NOT UNDER CONTRACT JUNE 30, 1938 FOR WHICH FUNDS WERE AVAILABLE—Continued

	TB	Psy- chotic	Other NP	Gen- eral	Total	Domi- ciliary	Grand total
Beds available Dec. 31, 1938:							
Veterans' Administration facilities.....	5,217	28,493	2,172	17,304	53,186	15,885	69,071
Other Government.....	327	109	50	2,033	2,519	-----	2,519
Total.....	5,544	28,602	2,222	19,337	55,705	15,885	71,590
Work in progress Dec. 31, 1938.....	161	4,001	-----	4,045	8,207	2,189	10,396
Beneficiaries remaining Dec. 31, 1938:							
Veterans' Administration facilities.....	4,352	27,153	2,074	14,058	47,637	16,551	64,188
Other Government.....	327	109	50	2,033	2,519	-----	2,519
Total.....	4,679	27,262	2,124	16,091	50,156	16,551	66,707
Beds unoccupied Dec. 31, 1938.....	865	1,340	98	3,246	5,549	-666	4,883

*Fiscal year 1940*

Unobligated balance available for construction June 30, 1939.....	\$2,774,219.16
Appropriated Apr. 18, 1940.....	2,165,000.00
Appropriated June 27, 1940.....	1,000,000.00

	TB	Psy- chotic	Other NP	Gen- eral	Total	Domi- ciliary	Grand total
Beds available June 30, 1939:							
Veterans' Administration facilities.....	5,327	29,115	2,070	18,267	54,779	16,204	70,983
Other Government.....	250	90	89	2,563	2,992	-----	2,992
Total.....	5,577	29,205	2,159	20,830	57,771	16,204	73,975
Work in progress June 30, 1939.....	-----	4,156	-----	3,304	7,460	2,093	9,553
Beneficiaries remaining June 30, 1939:							
Veterans' Administration facilities.....	4,585	28,489	1,916	15,044	50,034	15,197	65,231
Other Government.....	286	104	89	2,269	2,748	-----	2,748
Total.....	4,871	28,593	2,005	17,313	52,782	15,197	67,979
Beds unoccupied June 30, 1939.....	706	612	154	3,517	4,989	1,007	5,996

## PROJECTS NOT UNDER CONTRACT JUNE 30, 1939, FOR WHICH FUNDS WERE AVAILABLE

Location	Beds <sup>1</sup>	Date of award
Atlanta, Ga.....	69 general.....	Oct. 7, 1939
Biloxi, Miss.....	50 general.....	( <sup>2</sup> )
Danville, Ill.....	69 neuropsychiatric.....	June —, 1939
Des Moines, Iowa.....	75 general.....	Dec. 14, 1939
Hot Springs, S. Dak.....	35 domiciliary.....	( <sup>2</sup> )
Jefferson Barracks, Mo.....	100 general.....	June —, 1939
Marion, Ill.....	180 general.....	Nov. 1, 1940
Do.....	366 domiciliary.....	
Marion, Ind.....	134 neuropsychiatric.....	
Mountain Home, Tenn.....	64 domiciliary.....	June —, 1939
Perry Point, Md.....	183 neuropsychiatric.....	Aug. 29, 1940
Roanoke, Va.....	165 neuropsychiatric.....	Jan. 17, 1940
San Francisco, Calif.....	59 general.....	
Tuscaloosa, Ala.....	43 neuropsychiatric.....	June —, 1940

<sup>1</sup> Total beds, 1,592.<sup>2</sup> Readjustment of space.

*Fiscal year 1940—Continued*

## PROJECTS NOT UNDER CONTRACT JUNE 30, 1939, FOR WHICH FUNDS WERE AVAILABLE—Continued

	TB	Psy- chotic	Other NP	Gen- eral	Total	Domi- ciliary	Grand total
Beds available Dec. 31, 1939:							
Veterans' Administration facilities.....	5,353	29,374	2,374	18,499	55,600	17,134	72,734
Other Government.....	250	90	74	2,578	2,992	-----	2,992
Total.....	5,603	29,464	2,448	21,077	58,592	17,134	75,726
Work in progress Dec. 31, 1939.....	6	3,245	-----	2,989	6,240	1,789	8,029
Beneficiaries remaining Dec 31, 1939:							
Veterans' Administration facilities.....	4,246	28,642	2,068	15,682	50,638	17,068	67,706
Other Government.....	258	91	74	2,319	2,742	-----	2,742
Total.....	4,504	28,733	2,142	18,001	53,380	17,068	70,448
Beds unoccupied Dec. 31, 1939.....	1,099	731	306	3,076	5,212	66	5,278

*Fiscal year 1941*

Unobligated balance available for construction June 30, 1940.....	\$3,973,577.74
Appropriated Apr. 5, 1941.....	3,500,000.00
Appropriated May 24, 1941.....	1,000,000.00

	TB	Psy- chotic	Other NP	Gen- eral	Total	Domi- ciliary	Grand total
Beds available June 30, 1940:							
Veterans' Administration facilities.....	5,206	33,038	2,126	19,267	59,637	18,497	78,134
Other Government.....	250	90	63	3,014	3,417	-----	3,417
Total.....	5,456	33,128	2,189	22,281	63,054	18,497	81,551
Work in progress June 30, 1940.....	-----	321	-----	2,187	2,508	314	2,822
Beneficiaries remaining June 30, 1940:							
Veterans' Administration facilities.....	4,460	30,142	2,085	15,984	52,671	16,320	68,991
Other Government.....	228	89	63	2,374	2,754	-----	2,754
Total.....	4,688	30,231	2,148	18,358	55,425	16,320	71,745
Beds unoccupied June 30, 1940.....	768	2,897	41	3,923	7,629	2,177	9,806

## PROJECTS NOT UNDER CONTRACT JUNE 30, 1940 FOR WHICH FUNDS WERE AVAILABLE

Location	Beds <sup>1</sup>	Date of award
Marion, Ill.....	160 general.....	Nov 1, 1940
Do.....	367 domiciliary.....	
Marion, Ind.....	134 neuropsychiatric.....	Aug 29, 1940
Perry Point, Md.....	179 neuropsychiatric.....	
Roanoke, Va.....	164 neuropsychiatric.....	May 23, 1941

<sup>1</sup> Total beds, 1,004.

	TB	Psy- chotic	Other NP	Gen- eral	Total	Domi- ciliary	Grand total
Bed available Dec. 31, 1940:							
Veterans' Administration facilities.....	5,105	33,044	2,445	20,727	61,321	18,425	79,746
Other Government.....	250	90	85	2,992	3,417	-----	3,417
Total.....	5,355	33,134	2,530	23,719	64,738	18,425	83,163
Work in progress Dec. 31, 1940.....	-----	540	-----	753	1,293	321	1,614
Beneficiaries remaining Dec. 31, 1940:							
Veterans' Administration facilities.....	3,948	30,295	2,452	16,668	53,363	17,400	70,763
Other Government.....	264	91	85	2,341	2,781	-----	2,781
Total.....	4,212	30,386	2,537	19,009	56,144	17,400	73,544
Beds unoccupied Dec. 31, 1940.....	1,143	2,748	-7	4,710	8,594	1,025	9,619



*Fiscal year 1942*

Unobligated balance available for construction June 30, 1941.....	\$2,955,018.29
Appropriated June 27, 1942.....	4,557,000.00
Appropriated under the 10-year program as of June 30, 1941.....	3,000,000.00

	TB	Psy- chotic	Other NP	General	Total	Domi- ciliary	Grand total
<b>Beds available June 30, 1941:</b>							
Veterans' Administration facilities.....	5,102	33,350	2,540	20,857	61,849	18,747	80,596
Other Government.....	250	90	50	2,842	3,232		3,232
<b>Total.....</b>	<b>5,352</b>	<b>33,440</b>	<b>2,590</b>	<b>23,699</b>	<b>65,081</b>	<b>18,747</b>	<b>83,828</b>
<b>Work in progress June 30, 1941.....</b>		486		494	980	-41	939
<b>Beneficiaries remaining June 30, 1941:</b>							
Veterans' Administration facilities.....	4,343	31,109	2,453	16,717	54,622	13,926	68,548
Other Government.....	248	83	78	2,161	2,570		2,570
<b>Total.....</b>	<b>4,591</b>	<b>31,192</b>	<b>2,531</b>	<b>18,878</b>	<b>57,192</b>	<b>13,926</b>	<b>71,118</b>
<b>Beds unoccupied June 30, 1941.....</b>	<b>761</b>	<b>2,248</b>	<b>59</b>	<b>4,821</b>	<b>7,889</b>	<b>4,821</b>	<b>12,710</b>

PROJECTS NOT UNDER CONTRACT JUNE 30, 1941, FOR WHICH FUNDS WERE AVAILABLE

Location	Beds <sup>1</sup>	Date of award
Canandaigua, N. Y.....	164 neuropsychiatric.....	May 3, 1943
Chillicothe, Ohio.....	90 neuropsychiatric.....	June —, 1942
Marion, Ind.....	134 neuropsychiatric.....	Mar. 30, 1943
Fort Howard.....	250 general.....	July 25, 1941
Newington, Conn.....	15 general.....	July —, 1941
West Roxbury, Mass.....	300 general.....	Mar. 11, 1942

<sup>1</sup> Total beds, 962.

	TB	Psy- chotic	Other NP	General	Total	Domi- ciliary	Grand total
<b>Beds available Dec. 1, 1941:</b>							
Veterans' Administration facilities.....	5,193	33,364	2,538	20,750	61,845	18,725	80,570
Other Government.....	250	90	42	2,850	3,232		3,232
<b>Total.....</b>	<b>5,443</b>	<b>33,454</b>	<b>2,580</b>	<b>23,600</b>	<b>65,077</b>	<b>18,725</b>	<b>83,802</b>
<b>Beneficiaries remaining Nov. 30, 1941:</b>							
Veterans' Administration facilities.....	4,653	31,444	2,470	17,028	55,595	15,809	71,404
Other Government.....	256	86	83	2,170	2,595		2,595
<b>Total.....</b>	<b>4,909</b>	<b>31,530</b>	<b>2,553</b>	<b>19,198</b>	<b>58,190</b>	<b>15,809</b>	<b>73,999</b>
<b>Beds unoccupied Nov. 30, 1941.....</b>	<b>534</b>	<b>1,924</b>	<b>27</b>	<b>4,402</b>	<b>6,887</b>	<b>2,916</b>	<b>9,803</b>

*Fiscal Year 1943*

Unobligated balance available for construction June 30, 1942.....	\$2,706,949.22
Appropriated June 26, 1943.....	4,557,000.00
Appropriated under the 10-year program, as of June 30, 1942.....	6,107,000.00

	TB	Psy- chotic	Other NP	General	Total	Domi- ciliary	Grand total
<b>Beds available June 30, 1942:</b>							
Veterans' Administration facilities.....	5,524	33,709	2,475	20,745	62,453	18,371	80,824
Other Government.....	250	90	50	2,507	2,897		2,897
<b>Total.....</b>	<b>5,774</b>	<b>33,799</b>	<b>2,525</b>	<b>23,252</b>	<b>65,350</b>	<b>18,371</b>	<b>83,721</b>
<b>Work in progress June 30, 1942.....</b>	<b>33</b>	<b>351</b>		<b>764</b>	<b>1,148</b>	<b>78</b>	<b>1,226</b>
<b>Beneficiaries remaining June 30, 1942:</b>							
Veterans' Administration facilities.....	4,723	31,599	2,397	14,487	53,206	11,506	64,712
Other Government.....	207	80	50	1,622	1,959		1,959
<b>Total.....</b>	<b>4,930</b>	<b>31,679</b>	<b>2,447</b>	<b>16,109</b>	<b>55,165</b>	<b>11,506</b>	<b>66,671</b>
<b>Beds unoccupied June 30, 1942.....</b>	<b>844</b>	<b>2,120</b>	<b>78</b>	<b>7,143</b>	<b>10,185</b>	<b>6,865</b>	<b>17,050</b>

*Fiscal year 1943—Continued*

## PROJECTS NOT UNDER CONTRACT JUNE 30, 1942, FOR WHICH FUNDS WERE AVAILABLE

Location	Beds <sup>1</sup>	Date of award
Canandaigua, N. Y. ....	164 neuropsychiatric ..	May 3, 1943
Dearborn, Mich. ....	100 general ..	Feb. 8, 1945
Los Angeles, Calif. ....	120 general ..	
Marion, Ill. ....	367 domiciliary ..	
Do. ....	134 neuropsychiatric ..	Mar. 30, 1943
Pennsylvania ....	400 neuropsychiatric ..	Nov. 24, 1944
San Fernando, Calif. ....	24 tuberculosis ..	July —, 1943

<sup>1</sup> Total beds, 1,309.

	TB	Psy- chotic	Other NP	Gen- eral	Total	Domi- ciliary	Grand total
Beds available Dec. 31, 1942:							
Veterans' Administration facilities .....	5,607	33,741	2,602	20,713	62,663	18,453	81,116
Other Government .....	250	90	42	2,515	2,897		2,897
Total .....	5,857	33,831	2,644	23,228	65,560	18,453	84,013
Work in progress Dec. 31, 1942 .....	13	199		711	923	14	937
Beneficiaries remaining Dec. 31, 1942:							
Veterans' Administration facilities .....	4,539	31,143	2,551	13,518	51,751	10,628	62,379
Other Government .....	176	82	41	1,232	1,531		1,531
Total .....	4,715	31,225	2,592	14,750	53,282	10,628	63,910
Beds unoccupied Dec. 31, 1942 .....	1,142	2,606	52	8,478	12,278	7,825	20,103

*Fiscal year 1944*

Unobligated balance available for construction June 30, 1943 .....	\$4,584,448.52
Appropriated Dec. 23, 1943 (last appropriation for neuropsychiatric projects in 10-year program) .....	10,356,000.00
Appropriated Apr. 1, 1944 .....	31,650,000.00
Appropriated under the 10-year program as of June 30, 1943 .....	10,357,000.00
Appropriated June 27, 1944 .....	7,374,500.00

	TB	Psy- chotic	Other NP	Gen- eral	Total	Domi- ciliary	Grand total
Beds available June 30, 1943:							
Veterans' Administration facilities (regular) .....	5,996	33,771	2,444	19,553	61,764	18,455	80,219
Veterans' Administration facilities (emergency) .....		3,505			3,505		3,505
Other Government .....	250	90	49	2,206	2,595		2,595
Total .....	6,246	37,366	2,493	21,759	67,864	18,455	86,319
Work in progress June 30, 1943 .....	696	1,119		712	2,527	14	2,541
Beneficiaries remaining June 30, 1943:							
Veterans' Administration facilities .....	4,833	33,086	2,638	13,627	54,184	9,069	63,253
Other Government .....	189	81	49	1,374	1,693		1,693
Total .....	5,022	33,167	2,687	15,001	55,877	9,069	64,946
Beds unoccupied June 30, 1943 .....	1,224	4,199	—194	6,758	11,987	9,386	21,373

*Fiscal year 1944—Continued*

PROJECTS NOT UNDER CONTRACT JUNE 30, 1943, FOR WHICH FUNDS WERE AVAILABLE

Location	Beds <sup>1</sup>	Date of award
Dearborn, Mich.....	260 general.....	Feb. 8, 1945
Dwight, Ill.....	104 general.....	Jan. 23, 1945
Hines, Ill.....	500 general.....	
Knoxville, Iowa.....	160 neuropsychiatric.....	Oct. 14, 1943
Lebanon, Pa.....	400 General.....	Nov. 24, 1944
Lexington, Ky.....	164 neuropsychiatric.....	Jan. 7, 1944
Los Angeles, Calif.....	120 domiciliary.....	
Minneapolis, Minn.....	40 general.....	
Oteen, N. C.....	284 tuberculosis.....	July —, 1943
Sioux Falls, S. Dak.....	150 general.....	
Sunmount, N. Y.....	68 tuberculosis.....	Jan. —, 1944
Tuskegee, Ala.....	186 neuropsychiatric.....	Aug. 21, 1943
Waukesha, Wis.....	300 tuberculosis.....	Jan. —, 1944
Wood, Wis.....	700 tuberculosis.....	July —, 1943

<sup>1</sup> Total beds, 2,806.

	TB	Psy- chotic	Other NP	General	Total	Domi- ciliary	Grand total
<b>Beds available Dec. 31, 1943:</b>							
Veterans' Administration facilities (regular).....	6,626	38,075	2,572	20,310	67,583	16,393	83,976
Veterans' Administration facilities (emergency).....		4,813		1,029	5,842	228	6,070
Other Government.....	250	90	27	2,228	2,595		2,595
<b>Total.....</b>	<b>6,876</b>	<b>42,978</b>	<b>2,599</b>	<b>23,567</b>	<b>76,020</b>	<b>16,621</b>	<b>92,641</b>
<b>Work in progress Dec. 31, 1943.....</b>	<b>1,308</b>	<b>3,834</b>		<b>608</b>	<b>5,750</b>	<b>-1,635</b>	<b>4,115</b>
<b>Beneficiaries remaining Dec. 31, 1943:</b>							
Veterans' Administration facilities.....	5,312	34,469	2,778	14,468	57,027	9,950	66,977
Other Government.....	202	81	27	1,454	1,764		1,764
<b>Total.....</b>	<b>5,514</b>	<b>34,550</b>	<b>2,805</b>	<b>15,922</b>	<b>58,791</b>	<b>9,950</b>	<b>68,741</b>
<b>Beds unoccupied Dec. 31, 1943.....</b>	<b>1,362</b>	<b>8,428</b>	<b>-206</b>	<b>7,645</b>	<b>17,229</b>	<b>6,671</b>	<b>23,900</b>

*Fiscal year 1945*

Unobligated balance available for construction June 30, 1944.....	\$35,312,394.80
Appropriated Dec. 22, 1944.....	10,571,000.00
Appropriated May 3, 1945.....	84,500,000.00

	TB	Psy- chotic	Other NP	General	Total	Domi- ciliary	Grand total
<b>Beds available June 30, 1944:</b>							
Veterans' Administration facilities (regular).....	7,654	34,584	2,794	19,712	64,744	14,530	79,274
Veterans' Administration facilities (emergency).....		5,761		3,097	8,858	437	9,295
Other Government.....	250	90	37	4,051	4,428		4,428
<b>Total.....</b>	<b>7,904</b>	<b>40,435</b>	<b>2,831</b>	<b>26,860</b>	<b>78,030</b>	<b>14,967</b>	<b>92,997</b>
<b>Work in progress June 30, 1944.....</b>	<b>407</b>	<b>8,926</b>		<b>58</b>	<b>9,391</b>		<b>9,391</b>
<b>Beneficiaries remaining June 30, 1944:</b>							
Veterans' Administration facilities.....	5,970	36,398	2,955	15,066	60,389	8,647	69,036
Other Government.....	197	77	37	1,980	2,291		2,291
<b>Total.....</b>	<b>6,167</b>	<b>36,475</b>	<b>2,992</b>	<b>17,046</b>	<b>62,680</b>	<b>8,647</b>	<b>71,327</b>
<b>Beds unoccupied June 30, 1944.....</b>	<b>1,737</b>	<b>3,960</b>	<b>-161</b>	<b>9,814</b>	<b>15,350</b>	<b>6,320</b>	<b>21,670</b>



*Fiscal year 1945—Continued*

## PROJECTS NOT UNDER CONTRACT JUNE 30, 1944, FOR WHICH FUNDS WERE AVAILABLE

Location	Beds <sup>1</sup>	Date of award
American Lake, Wash.....	492 neuropsychiatric.....	
Bedford, Mass.....	85 neuropsychiatric.....	Apr. 4, 1945
Coatesville, Pa.....	328 neuropsychiatric.....	July —, 1944
Dearborn, Mich.....	260 general.....	Feb. 8, 1945
Dwight, Ill.....	104 general.....	Jan. 23, 1945
Fargo, N. Dak.....	205 general.....	
Fort Harrison, Mont.....	250 general.....	
Fort Lyon, Colo.....	328 neuropsychiatric.....	
Gulport, Miss.....	164 neuropsychiatric.....	Mar. 5, 1945
Hines, Ill.....	600 general.....	
Lohanon, Pa.....	522 neuropsychiatric.....	Nov. 24, 1944
Lexington, Ky.....	492 neuropsychiatric.....	Mar. 8, 1945
Livermore, Calif.....	100 tuberculosis.....	
Los Angeles, Calif.....	1,232 neuropsychiatric.....	2 Nov. 29, 1944
Marion, Ind.....	75 neuropsychiatric.....	Nov. —, 1944
Murfreesboro, Tenn.....	492 neuropsychiatric.....	Mar. 14, 1945
New York, N. Y.....	1,492 neuropsychiatric.....	
North Little Rock, Ark.....	656 neuropsychiatric.....	Sept. 22, 1924
Perry Point, Md.....	328 neuropsychiatric.....	Aug. 25, 1944
Sheridan, Wyo.....	164 neuropsychiatric.....	July 24, 1944
Sioux Falls, S. Dak.....	150 general.....	(3)
Sturcis, S. Dak.....	700 neuropsychiatric.....	(3)
Tuscaloosa, Ala.....	328 neuropsychiatric.....	Jan. 4, 1945
Waco, Tex.....	164 neuropsychiatric.....	Aug. 12, 1944
Wadsworth, Kans.....	1,496 neuropsychiatric.....	(1)
Wisconsin.....	1,328 neuropsychiatric.....	Apr. 19, 1945

<sup>1</sup> Total beds, 12,535.<sup>2</sup> 432 beds.<sup>3</sup> From War Department—Opened May 15, 1945.<sup>4</sup> Conversion completed Apr. 30, 1945.

	TB	Psy- chotic	Other NP	Gener- al	Total	Domi- ciliary	Grand total
Beds available Dec. 31, 1944:							
Veterans' Administration facilities (regu- lar).....	7,724	35,962	2,998	19,658	66,342	14,433	80,775
Veterans' Administration facilities (emer- gency).....	9	6,061	-----	3,185	9,255	437	9,692
Other Government.....	250	90	35	4,053	4,428	-----	4,428
Total.....	7,983	42,113	3,033	26,896	80,025	14,870	94,895
Work in progress Dec. 31, 1944.....	354	12,520	-----	155	13,029	-1,689	11,340
Beneficiaries remaining Dec. 31, 1944:							
Veterans' Administration facilities.....	5,755	37,452	3,215	15,405	61,827	9,321	71,148
Other Government.....	175	80	35	2,159	2,449	-----	2,449
Total.....	5,930	37,532	3,250	17,564	64,276	9,321	73,597
Beds unoccupied Dec. 31, 1944.....	2,053	4,581	-217	9,332	15,749	5,549	21,298

Unobligated balance available for construction Apr. 30, 1945..... \$1,689,736.97

Unallocated balance available for construction Apr. 30, 1945..... 14,366,306.85

Appropriated May 3, 1945..... 84,500,000.00

	TB	Psy- chotic	Other NP	Gener- al	Total	Domi- ciliary	Grand total
Beds available Apr. 30, 1945:							
Veterans' Administration facilities (regu- lar).....	8,117	38,847	3,317	19,186	69,467	13,660	83,127
Veterans' Administration facilities (emer- gency).....	9	6,426	-----	3,421	9,856	437	10,293
Other Government.....	250	90	33	4,055	4,428	-----	4,428
Total.....	8,376	45,363	3,350	26,662	83,751	14,097	97,848
Work in progress Apr. 30, 1945.....	218	11,813	-----	1,077	13,108	2,069	15,177
Beneficiaries remaining Apr. 30, 1945:							
Veterans' Administration facilities.....	6,772	39,478	3,580	17,245	67,075	9,155	76,230
Other Government.....	145	79	33	2,644	2,901	-----	2,901
Total.....	6,917	39,557	3,613	19,889	69,976	9,155	79,131
Beds unoccupied Apr. 30, 1945.....	1,459	5,806	-263	6,773	13,775	4,942	18,717

General HINES. That naturally would lead to the question why we did not anticipate this program faster. I might say that at the time—we can commence in 1940, which was prior to Pearl Harbor—we had a building program for World War I patients. World War II was not in the picture, although we were entering the training period. At that time the policy approved by the President did not require the Veterans' Administration to build more. Our beds were not all filled at that time. As a matter of fact, to tide over while the Army attempted to get ready they used some of our facilities. One of the outstanding uses was at Los Angeles, where a complete NP hospital was used as an evacuation hospital by the Army.

Soon after Pearl Harbor recommendation was made to the Board that the remaining beds in the 10-year construction program be expedited. We ran into exactly what could be anticipated, and that was when the Army and Navy started building their facilities, there was no way that we could get competition.

I feel that the program has progressed rapidly and, of course this committee knows, without my telling it, that when we undertook to take in the non-service-connected cases of this war, we ran into an unusual load that neither the committee nor the Veterans' Administration could anticipate, and that has brought about a situation which is more responsible for any crowding than anything else. However, I must say that I doubt if anybody anticipated at the end of the training period that the War Department would discharge as many men in a given time.

I think it would be interesting at this point if I called your attention to the effect of the load on the Veterans' Administration, and, mind you, we had practically reached the peak of the NP load of World War I, but commencing through March of 1941 to March of 1942 the total hospitalization requested of World War II veterans was 943. I have the data, month by month, up to April of this year. It indicated that a total of 167,325 patients of World War II have gone in Veterans' Administration hospitals.

The CHAIRMAN. How many are service connected?

General HINES. I will give you that in detail; there were 15,249 TB; 46,471 NP; 104,470 general cases; 1,535 domiciliary.

To break that down further, and before doing so I might point out that March of 1945 was the largest month in numbers, when we received in our hospitals a total of 10,172. To break those down by service connected and nonservice connected, of the total of 165,790, service-connected cases were 47,806, nonservice 117,984.

The CHAIRMAN. How many of the non-service-connected cases were affected with what we call chronic constitutional diseases, such as tuberculosis.

General HINES. I have the tuberculosis group broken down. The total tuberculosis, pulmonary, was 15,249. Out of that group 10,443 were service connected; 4,816 nonservice.

I might say that that group all the way through, the great majority of them, are service-connected cases, and they, of course, need hospitalization. The Army has been prompt in turning them over to us, as well as the neuropsychiatric group. In that group we had a total of 46,071; service connected 19,894, broken into two groups—those that are definitely mental cases, psychotic cases, 16,949, and other neuropsychiatric cases, 2,945; non-service-connected cases, 26,177,

of which 17,544 were psychotic, 8,629 were other neuropsychiatric disabilities.

The greatest number of the nonservice cases occurs in the general and surgical cases, where out of a total of 104,470, 86,991 were nonservice-connected cases.

Mr. SCRIVNER. That made how many service connected?

General HINES. It made 17,479.

Mr. SCRIVNER. That would be less than 20 percent.

The CHAIRMAN. General, if the veterans' hospitals were used exclusively for service-connected cases and for ex-servicemen suffering from chronic constitutional diseases, what effect would that have on the load?

General HINES. That would very materially reduce the load; it would slow up the building. If that were adopted as a permanent policy, it would enable us to take care of those cases, I think, with the present personnel.

But let me call the committee's attention to this fact; that as I am testifying here today, the building program is ahead of the personnel program. In other words, if I could get nurses and doctors, we could open up 1,400 additional beds that are now ready to be opened up.

Mrs. ROGERS. Before you get off that, will you give us the figure of service-connected veterans, men and women, that you have in nonveterans' hospitals, such as State, and so forth?

General HINES. Yes; I have that in another chart. That would include Army and Navy, as well as other contract.

Mrs. ROGERS. Yes; in all hospitals. You have, of course, a very large number of service-connected cases still in the Army and Navy hospitals.

General HINES. Out of a total load, April 30, 1945, of all kinds, including domiciliary, we had 80,421; of that number, 67,075 were in Veterans' Administration facilities, 820 in marine hospitals, 75 in St. Elizabeths hospital.

Mrs. ROGERS. What cases are those; men or women?

General HINES. Those are all men, I believe, in St. Elizabeths, and they are generally committed cases.

Mrs. ROGERS. Are there any women in St. Elizabeths?

General HINES. Our women now are going into our own hospitals, like Perryville.

I didn't finish this: The Navy has 1,297, and civil and State institutions, 1,290. Then we had a total in our own domiciliary facilities of 9,166. Of course, before the war the Army and Navy hospitals had a large number of our cases, and it is contemplated that they will do so again.

In our total estimate of the beds required, 300,000 at the peak, assuming there is no change in the legislation, it is contemplated that where we are building 130,000-some beds in our own institutions, that up to 200,000 of those beds will come from the Army and Navy, either from the hospitals which have been built and designed primarily to be turned over to us; that is, the permanent construction plants located at Richmond, Hines, Ill. In Georgia we have one built by the Navy, a new one planned at Austin, Tex., that will be turned over. But in addition to that, if we continue the present program, it is my judgment that we will have to build an additional 100,000 beds.



I would like to suggest to the committee——

Mr. SCRIVNER. By when?

General HINES. By 1975. That building would be a gradual program, because the peak of hospitalization will not occur immediately following the war; it will gradually increase as these men get older. And we have found also there is the factor of becoming more familiar with the use of hospitalization, more men come in as time goes on.

Mrs. ROGERS. Is it not true that not until 1949 will the peak of World War I veteran cases be reached?

General HINES. We reached the peak, as a matter of fact, in those cases in 1942.

Mrs. ROGERS. That is earlier than was anticipated?

General HINES. It is really ahead of what was anticipated. As a matter of fact, our original calculations I think put that peak at about 1949, but we have reached it certainly between 1942 and 1944. You cannot always tell, because economic conditions have a great bearing upon that and since we got into this war many of the milder type of cases found employment and did not return to hospitalization, but if we continue with the present law, I think it is safe to say that we would have to build up to 300,000.

Now, there are two ways that building may be reduced, and one is by going further into the matter of out-patient treatment, by the establishment in the larger centers—and this is where I do believe the medical centers of the civilian set-up can be helpful—by establishing neuropsychiatric clinics for out-patient treatment where these men of the milder type, who after certain test visits at the hospitals find they are again feeling in need of hospitalization, can go to those clinics. I feel a number of those would not go into the hospitals.

Likewise, I feel that with a little liberalization of certain types of general cases, you will be able to reduce building, because as it is now, non-service-connected cases will have to be placed in a hospital to get any form of treatment; the service-connected cases can always be treated on an out-patient basis for service disabilities.

So I feel that in your study of the hospital situation that it would be well to give consideration, when you come to apply any remedies you feel are needed following this very thorough study, that you take into account the question of whether it would not be feasible to liberalize the out-patient feature of the case.

Mrs. ROGERS. You spoke of the shortage of nurses and doctors. You would be willing, would you not, to approve of the veterans' Medical Corps bill that was here sometime ago?

General HINES. I have some rather interesting information on the Medical Corps bill that I was going to take up when I touched on personnel. As a matter of fact, it was not long after I was appointed Director of the Veterans' Bureau that I recommended a Medical Corps bill. The committee had hearings on it, and I will give you that history in a few minutes.

Of course, the question naturally arises on the Medical Corps bill as to why it was not pressed following that. It came up several times, but, as a matter of fact, it was generally not supported by the service organizations, nor was it supported entirely by the doctors themselves. I think the Legion has a clear-cut record of having recommended it.

quite a ways back, but I would like to proceed, before I go on with that, with the question of building.

Even at this time, with the Army and Navy not building to any great extent, they are converting from time to time, and we are getting good competition, but it was not very far back as Colonel Tripp and Colonel Ijams outlined in their statements to the committee, when we could not obtain competition or get bids at all. There are certain materials now that are critical, lumber being the outstanding one. The War Production Board, I am sure, has tried to be fair, but it was not until the GI bill was passed, the Servicemen's Adjustment Act, that we were rated as a war agency, and had any chance at all in getting priorities.

Mrs. ROGERS. Would it not be very helpful if you had a department of veterans' affairs, or a Cabinet head, in procuring priorities?

General HINES. Well, Mrs. Rogers, I have never served in a Cabinet position, but I must say that the Veterans' Administration and its predecessor, under all of the Presidents I have served under—I am sure there has never been a time when I could not see the President on any issue that required his attention. I have felt, looking to the future rather than what we have gone through, that the expenditures for the Veterans' Administration in the future, where we have just entered on a year where the expenditure is \$2,700,000,000, or will be if our estimates are near right, and may be larger, that with that expenditure on the part of one agency of the Federal Government, if I were President I believe I would like to have whoever is running that institution sitting at the Cabinet table. I think it will have such a bearing on what is done in other departments of the Government—it is larger than two or three of them put together—that the advice of that official ought to be helpful to the other members of the Cabinet. I have never felt in dealing with it up to the present moment that I have been handicapped. Maybe I have. I am not going to ask anyone to accept responsibility for any error of judgment that I have made; I am willing to take that upon myself.

We have tried to anticipate the needs. We have suffered more on personnel needs than anything else, and that has been due entirely to the fact, not that I couldn't get an audience with the President, or with anyone else—it has been due to the fact, and the important fact, that after Pearl Harbor, when the war effort was greatest, when our whole Government machinery was thinking in terms of how to do things for the Army and Navy to win the war, that an agency that was not a war agency was not necessarily going to get priorities in the matters of material and personnel.

The original list of priorities was issued, so far as I know, without conferring with very many agencies. We came out of that with a bad score; we were rated very low. We immediately undertook to get the priority we felt we deserved back, and from day to day, in all of these things you naturally believe the time is coming when somebody is going to agree with you and advance it, so time goes by without you realizing it and finally you get to the point where you do have to go to the President.

The Veterans' Administration hospitals suffered, when the war started, in two ways. First, industry was paying high wages, and it attracted one important group from our hospitals. That was attendants. They not only were drafted to go into the service, but



they left of their own accord to take positions paying more. We undertook to try to overcome that by different steps, increasing pay, and so on, but at no time could we very well reach a point to compete with industry in their pay scales and their overtime.

Our doctors, many of them, were particularly anxious to serve. They did not wish to stay in the hospitals, they wanted to serve, and you cannot blame them very much. Nevertheless, we lost to the services 450 physicians, 988 nurses, 106 technicians, 15 dentists, 17 dental mechanics, 5 dental assistants and 1 dental hygienist.

Mr. GIBSON. In that connection, not only did you lose them, but very soon thereafter your load increased.

General HIXES. You are quite correct. Our load was increasing soon after, not immediately. But the great difficulty was there was no replacement. The replacements are still few and far between. As a matter of fact, I can't help but refer to it, and I know that the gentleman that made the remark was perfectly sincere, but I appeared before the Procurement and Assignment Committee. The Procurement and Assignment Committee was set up by the President in connection with War Manpower to avoid drawing out of any community all of the doctors, to keep a suitable number of doctors in all communities, so that men drawn into the service for the Army and Navy were channeled through this Procurement and Assignment Committee. Months went by and we could never get any doctors from the Procurement and Assignment Committee, so finally I asked for an appearance before them, based on the thought that if I couldn't get action there I would go to the President. They gave me a hearing; they listened to me. I thought I had made a very good case, when one of the members of that committee said, "Why, General, you have more doctors and nurses than you need in your hospitals." That was after we had lost this number. Not only did he make that statement at that hearing, but he came to my office and tried to convince me. I know that he was basing his thought on what were the ratios of doctors to patients and nurses in normal times, not realizing the number of doctors we had lost, although I had tried to make it clear.

Mr. Stigler. This man who said that wasn't a doctor himself, was he?

General HIXES. Yes, he was; and a very high-rated doctor.

Finally the shortage and the danger of losing more reached the point where I had to see if I could persuade the Secretary of War and the General Staff to agree not to take any more nurses and doctors. Mind you, that was not even popular with our own doctors and nurses. Many of them wanted to go and serve. And I commend them for it. But they didn't realize that these hospitals could not be operated.

So, in April 1942, I went to see the Assistant Secretary of War, and from that time until—well, the last visit was in November 1943, I endeavored, either with Secretary McCloy, or the General Staff, to persuade them to find a way to hold my doctors and nurses. After many visits, the General Staff agreed with us that the doctors would be commissioned and put on detached duty in the Veterans' Administration hospitals. At those conferences I raised the issue also on attendants. I knew the time would come when we would be short on attendants. We were short then and gradually losing them, both by the draft and by their leaving for other employment.



At first, I think the General Staff did not feel it would be a good thing to put these enlisted men in our hospitals as attendants. I am sure, after learning the conditions as they grew, they finally agreed with me, so we have had to place in our hospitals, in order to continue their operation, about 8,000 attendants of various kinds. I received word the other day that the Army would be unable to furnish any more doctors, commissioned and put on detached duty, or any more attendants. I am hoping that General Bradley will have more influence with the General Staff than I had, and I think he will.

Now, our doctors were not commissioned and put on detached duty until the President himself issued the order. There was a difference of opinion, an honest difference, and finally I went to President Roosevelt and told him there was only one answer, we could lose no more doctors, we could not replace them. I suggested the best method was to commission them and put them on detached duty, and he issued the order. I am not sure to this day that it was agreeable to the War Department at that time, but they did it.

Now, there was one visit that helped us a great deal, and General Somervell is entitled to the credit. At the time the Army discharged, on certificate of disability, over a period of—well, 3 or 4 months—rather a short period, where approximately 500,000 men came out of the service, our rating of cases, adjudication of cases, fell very much behind, and I went to General Somervell's office, and he directed 100 medical officers be detailed by the Surgeon General's office to the Veterans' Administration to assist in that work. With that number from the Army I requested the Navy to give us some, and they did. The request was for 50. Without that help the adjudication of our cases would not have been where it is today, and the committee probably would be interested in knowing that a few days ago we passed the half million mark of men of World War II who are on the pension rolls of the Veterans' Administration. That means that nearly 900,000 cases have been adjudicated.

This duty that those officers have been assigned to is not agreeable to them. I think we should find a way, as soon as we can, to relieve them of that duty. We cannot do it until the Surgeon General—and I am glad to say that he indicated that they would—discharges a number of doctors. But I am not sure that we will get many of them under existing conditions, because there is the allure of private practice in a large measure at the present time, and many of them will go there.

Looking back over the picture, I cannot help but say to this committee that if I knew we were ever going to get into another war, I would certainly strongly advocate that you have a set up very much along the lines indicated in the medical corps bill. I would also go further and say that other personnel of the Veteran's Administration has been lost to the Army and Navy, and you cannot force men to stay when they wish to serve their country. That, too, has crippled the administration of that great agency. It is so close to the Army and Navy that it should be made a part, immediately upon the entrance of our country into a war, of the armed forces of the United States.

That doesn't necessarily mean that it becomes a part of the War Department, because the Constitution permits a set-up of that kind under the President, and its function under the Administrator of Veterans' Affairs.

They should also be permitted to get replacements from the draft, because the time will come when many men within the draft age would be pulled out of the service, as they have been. I am not sure of the number of men of the Veterans' Administration that are now serving, but I think probably we must have between 7,500 and 8,000 all told, that have gone in the service. We have adopted a rule that we would not ask for the deferment of any man that we could spare. Naturally we did have to ask for deferments of a few people in our hospitals from time to time, but the difficulty generally was that these men wanted to serve, they either wanted to go into the armed service, or they wanted to accept jobs in industry, so that deferment did not stop it. And there is only one answer that is safe, looking to the future, and now, looking back, if I had anticipated that it would have required as much effort and as much persuasion to keep these hospitals operating and keeping these officers operating, as was necessary, I would long since have had a bill up here and taken a chance with Congress on it.

Now, the question will naturally arise, if I felt it should be in the armed forces, why didn't I ask for it? I had discussed this with Mr. McCloy, Assistant Secretary, I had discussed it with President Roosevelt. There was strong opposition to civilian agencies, as we were then classed, having military personnel assigned to them. I think probably the difficulty will be found primarily in the draft law itself, because people do not care to be drafted and placed in what was then known as a civilian agency. However, it has been a difficult job for me, with rising conditions, increased work of over 300 percent, with personnel losses constantly.

I would like to read now to the committee, Mr. Chairman, a letter which was addressed to you and also to Senator George, of the Finance Committee, after the bill which this committee so promptly reported out to assist in personnel matters and space matters, to which I am glad you accepted yesterday the Senate amendments, which took the personnel feature out. I believe that this letter should be made a part of the record, because we have endeavored to give facts here which I believe adequately cover the personnel situation. [Reading:]

MY DEAR SENATOR GEORGE: I have been advised of the action of the Finance Committee, of which you are chairman, to report favorably H. R. 3118, eliminating from the bill as it was passed by the House of Representatives, the language which, if enacted, would authorize the Administrator of Veterans' Affairs to employ during the emergency, personnel of all categories without reference to the Civil Service and Classification Acts, but with due regard to veterans' preference. It is understood the committee action was on the basis of this matter being one properly for the consideration of another committee, but inasmuch as the matter may come up in the Senate and certainly in conference, should the two Houses disagree, I feel that you would desire an explanation of the objections which were raised, it is understood, by the Civil Service, as well as by the Bureau of the Budget, and voiced in the debate in the House of Representatives by Congressman Ramspeck; notwithstanding it was passed by the House by the overwhelming vote of 225 to 39 on June 4, 1945. Further, I feel that my successor, General Bradley, should not be handicapped as I have been in trying to bring the Veterans' Administration to a proper functioning basis.

I have stated without successful contradiction so far, and without fear thereof in the future, that all of the Administration's difficulties have been due to two factors: Lack of personnel and lack of adequate space. It was one of the purposes of the Servicemen's Readjustment Act of 1944, Public, 346, Seventy-Eighth Congress, to afford such priorities and other authority as would enable the Veterans' Administration to secure adequate qualified personnel and the space in which they might perform their essential functions in extending the benefits of relief to veterans and to the dependents of servicemen. In practice it has been found that this



objective was not accomplished under said act, and the amendment to section 100 thereof was proposed accordingly. The objections which have been voiced thereto are as follows: First, that section 100 of the present act does afford sufficient priority; second, that the Administrator of Veterans' Affairs has authority, outside of the departmental service in the District of Columbia, to fix the classification and the salary of any position; and third, that to employ even for the duration temporary employees without reference to Civil Service and Classification Acts would be destructive of the present Civil Service, in that it would destroy the morale of those presently enjoying civil-service positions in the Veterans' Administration, and therefore it would not aid in recruitment.

Aside from the fact that these contentions do not seem entirely consistent with themselves, and particularly that the proposed amendment would restrict the salaries to the ranges fixed for classified grades, it has not been brought to my attention, nor I believe to that of the Congress, that similar provisions during the emergency of World War I were destructive of civil service, or that similar statutes applicable to the Army, Navy, and Maritime Commission during the present war have had such effect.

I think you may find it pertinent at this point to relate the history of some of the developments that have led to this proposal. To begin with, I am sure you are aware of the fact that the responsibilities of the Veterans' Administration were approximately doubled by the Servicemen's Readjustment Act of 1944, and further that there has been a 300-percent increase in the work of the Veterans' Administration with respect to the benefits of pension, medical care, hospitalization and insurance provided in other basic statutes. While the Congress has evidenced every intent to afford the Administration sufficient authority, the following statement will illustrate some of the difficulties administratively encountered.

#### Then it continues:

In February of 1942 the Bureau of the Budget established a priority for employment purposes among Federal agencies, and at that time the Veterans' Administration was placed in priority class V, the lowest possible rating. The personnel problem of the Veterans' Administration very quickly assumed proportions potentially serious in character. Requests for transfer of employees increased sharply, and the Administration was unable to prevent losses in personnel who could secure higher grades in agencies having higher classifications. Likewise, so many of our key men being veterans of World War I, or otherwise being Reserve officers, the Administration lost a great number of its key personnel including its best doctors. Realizing that everything must be secondary to the winning of the war, few requests were made for retention of such personnel or for exemption from the draft; in fact, only an insignificant number of absolutely irreplaceable personnel were withheld from service in the armed forces. I made urgent appeals to the Director of the Bureau of the Budget with respect to other personnel and on April 17, 1942, those functions of the Administration associated with national service life insurance activities were placed in priority II. This action was of very little assistance and served to complicate administration as related to personnel. In August 1942, a class IV priority was given to three units, a class III for one, and class II was given to national service life insurance activities. The units so recognized were then comparatively small in relation to total personnel strength. On December 24, 1942, chiefly because of congressional action, the Administration finally secured recognition as a war agency from the Bureau of the Budget and was given the proper priority rating.

Another complicating factor in the Administration's personnel problem resulted from directives of the War Manpower Commission. Under these directives all Government departments or agencies, including the Veterans' Administration, were placed in category 5. After an appeal to the Commission, certain functions of the Administration were placed in category 3, which represents the highest authority for clerical-administrative positions in the Federal Government. This rating was confined to the central office clerical-administrative positions, whereas the Administration requires personnel for other than clerical and administrative duties in central office, not to mention our needs for the field service. Category 5 was continued for all these other positions. However, in some instances, the field offices of the War Manpower Commission recently have given favorable consideration to requests of the Administration for assistance with reference to certain types of positions in hospital services in order to staff additional beds. You will recall that we are completing a hospital program calling for some 16,000 additional beds, and are initiating another program calling for 26,000 additional beds.



None of these actions, however, enabled the Administration to compete with wage differentials and other factors governing the choice of jobs by prospective employees. Furthermore, even when applicants were willing to accept work immediately with the Veterans' Administration and were referred to the Civil Service representatives for certification, they simply refused to be bothered with the necessary examinations in order to secure civil-service status.

The enactment of section 100, Public Law 346, Seventy-eighth Congress, June 22, 1944, declared the congressional intent as to the Veterans' Administration being a war agency and gave full recognition to the importance of its functions. In actual operation, however, the Administration has reason to believe that, notwithstanding this legislation, it has not been accorded the priority intended by the Congress. Because of the tremendous increase in the volume and character of its work, the fact that proper recognition was not given the Administration early in the war, has served directly to complicate its numerous problems. In other words, we have a picture of constantly increasing activities and responsibilities with constant loss of efficient, qualified personnel, replaced, if at all, with untrained personnel, often leaving their positions for better jobs elsewhere before learning their work with the Veterans' Administration.

Throughout the emergency the Administration has made every effort to acquaint the Civil Service Commission with a proper recognition of its recruitment problems. There have been numerous conferences with representatives of that agency concerning that subject, typical of which were those held in the office of the President of the Commission on February 25 and November 5, 1945. On June 27, 1944, President Mitchell and two members of his staff attended a conference here in this office in connection with the Administration's recruiting difficulties. In addition there have been many appeals in writing on this general subject, illustrative of which are the attached letters marked "Exhibit A."

It becoming apparent in May 1943 that the Civil Service could not meet the demand for clerical personnel (clerks, typists and stenographers), it became necessary to supplement efforts by recruiting employees through the Administration's field offices. Since that time approximately 1,400 employees have been obtained through these methods. In response to a request from the Administration the Commission granted authority in June and November 1944 to appoint clerical employees (clerks, typists, and stenographers) on a temporary basis for assignment in central office by making local selections. Again this was due to the Commission's inability to meet our needs. The exact number of employees appointed under this authority is not available, but is estimated at approximately 900.

The lag in recruitment for clerical positions in the central office in Washington became so pronounced in March of this year, arrangements were made to designate one person at each of our field offices east of the Rocky Mountains to assist in recruiting and to assign one liaison representative for each Civil Service region, who, in conjunction with the Civil Service representative and with the approval of the Commission, are making a concerted effort to fill quotas set up for central office personnel. They have visited high schools, business schools, colleges, clubs, churches, and so forth. In addition, certain organizations have undertaken to recruit nurses and perhaps other personnel. Still further, approximately 50 percent of the central office activities were moved to New York City where both space and personnel at the time were available.

As I am sure you know, the Administration requires personnel in almost every grade, class and type of work, professional, subprofessional, clerical and administrative. It requires personnel in every State in the Union and the shortages are acute in areas such as Detroit, San Francisco and Los Angeles, where the manpower shortage has been most serious. As of April 1, 1945, the number of vacancies by classification services were:

Clerical, administrative, and fiscal, 5,886.

Professional and scientific, 2,959.

This is off-set by approximately 2,000 commissioned officers of the Army and Navy, over 1,200 being administration physicians commissioned by the Army.

Subprofessional 5,026.

Crafts, protective, and custodial, 2,329.

In the subprofessional and crafts, protective and custodial services are hospital attendants, mess attendants and laborers. The vacancies in these civilian positions are offset to an appreciable extent by approximately 6,500 enlisted men of the Army serving at the attendant level at 50 stations, and approximately 1,200 prisoners of war at 17 of our hospitals. This number of enlisted men does not represent replacement for the same number of employees in regular positions as it has been necessary to request the detail of limited service enlisted men in the ratio of

about two soldiers to one civilian employee because the soldiers have to drill, maintain their paper work, etc.

The doctors supplied by the Army and Navy were upon Presidential direction. The enlisted men were supplied direct in an agreement with the Secretary of War. It is only fair to say that these arrangements have been less than wholly satisfactory either to the personnel concerned or to the Veterans' Administration for reasons which are rather readily apparent.

Under the budget for the fiscal year ending June 30, 1946, several thousand additional positions will be required, and this agency will be confronted with the resultant recruitment problem in filling these jobs. At the present time there is a critical shortage of qualified physicians and of nurses, and in addition to that would be the needs for the thousands of additional beds which are being constructed. Personnel matters have been very largely decentralized to the managers of our field offices and facilities except, of course, professional and key personnel. In August 1944 the Veterans' Administration advised the Civil Service Commission that all positions filled from Civil Service registers for duty in the field offices should be decentralized to the regional directors of the Civil Service Commission, with the exception of 32 positions out of 400 different types. The Commission has since that date taken action to comply with our request. During the period January 1, 1945, to May 31, 1945, 10,136 personnel actions were processed in the central office for the central office and the field areas. During the same period 38,178 personnel transactions were processed in our field offices.

The statement that the Administrator of Veterans' Affairs has authority to establish classifications and rates of pay for field offices is simply not in accordance with fact. The fact is that the Administrator has no authority to allocate positions to classification grades or to establish pay rates other than in accordance with the principles embodied in the Classification Act of 1923, as amended. There is a long line of Comptroller General's decisions holding in effect that under the authority of the law and the Executive order permitting the heads of agencies to extend classification to field positions the principles of classification require that the duties and responsibilities of field positions be allocated as far as may be practical in the same manner as those existing in the departmental service. Further, the proposed amendment does not authorize any departure from classification principles, but simply permits the fixing of pay within the established grades provided for similarly classified positions.

It is contended that the proposed provisions would have the effect of disrupting the present civil service and of retarding rather than expediting the filling of vacancies in the Veterans' Administration. The act would not affect any employee at present in a civil-service position. All employees of the Veterans' Administration are under civil service either in permanent or temporary appointments, and their rights and status would remain unchanged. Relatively few of them are now at the minimum pay scale, and even if, for emergency purposes, it should be found necessary to pay newly recruited employees at a higher rate, such employees would lack all of the civil service and retirement rights now enjoyed by employees in the Veterans' Administration. The act does provide that through regular competition they may secure, in due course of time, a civil-service status, but if they do not do so their employment must cease not later than one year after the termination of the war. But let it be assumed that some regular employees would feel discriminated against. This act is intended to serve disabled veterans and the widows and orphans of those who are killed in the war, and not for the sole interest of civil-service employees. The Administration has had some experience in this respect which will illustrate the converse of the contention that recruitment would be retarded. In August 1942, the Civil Service Commission authorized the Administration to appoint nurses without the prior approval of the Commission. Since the receipt of this authority approximately 4,100 nurses have been appointed, less than 1 percent of whom were secured from civil-service registers. On several occasions since September 1942 request has been made of the Civil Service Commission that the Veterans' Administration be authorized to employ stenographers without prior approval of the Commission. Where such authority has been granted, results have been favorable.

Finally, it has been contended that the Administration does not supply adequate transportation facilities for its employees who are required to travel considerable distances in order to work at its facilities, and that it has not supplied adequate quarters for certain types of employees at its facilities. I am sure you realize that there is a very strict statute absolutely forbidding the use of Government transportation except for authorized purposes. The Congress, upon my request, did, in Public Law 170, Seventh-Eighth Congress, authorize the



Administration to use Government-owned vehicles for its employees in the absence of adequate public or private transportation. Under this law the authority granted the Administrator may be exercised with respect to any station only after determination by the Office of Defense Transportation that existing private or public facilities are not and cannot be rendered adequate by any other means, and that its exercise will result in the most efficient method of supplying transportation to the personnel concerned and the utilization of transportation facilities consistent with the plans, policies, and purposes of the Office of Defense Transportation. Further, with the exception of one or two instances, in some of the older facilities taken over from some of the other governmental agencies, the quarters furnished employees at the Veterans' Administration facilities meet the generally required standards for housing of this kind.

The Veterans' Administration has always adhered to civil-service and veterans' preference principles; and there would be no difficulty in giving effect to veterans' preference as would be required by the bill. Numerous similar acts are Public Law 372, 365, 374, and 358, all of the Seventy-eighth Congress.

The Civil Service Commission itself has recognized that the requirement of existing law that employment be commenced at the minimum of the grade is a handicap in securing personnel. In its sixty-first annual report, for the fiscal year ending June 30, 1944, page 4, the Commission stated:

"The executive branch should have more freedom in determining the rates of pay, within the ceilings established by the Congress, at which employees may be hired; and while the Commission recommends that it be given authority to establish entrance rates of pay above the minimum now provided by law, it would appear that pending the enactment of such a general law, the Veterans' Administration may properly be given such authority temporarily to supplement civil-service recruitment.

The Veterans' Administration has earnestly endeavored to operate within the confines of the Classification Act and other laws governing the employment of Federal personnel. The Civil Service Commission has been sympathetic and has cooperated with the Veterans' Administration, but the Veterans' Administration has been unable to compete with other agencies and with private employment in securing necessary personnel, and the Veterans' Administration is convinced that drastic action must be taken if it is to secure adequate personnel to perform the important and vital duties for which it was established.

In conclusion, may I say for your consideration, for the possible benefit of my successor in office, and with a view to adequate service to those to whom we all owe so much, the Veterans' Administration, no matter how it is organized, can be made to function efficiently only if it has adequate qualified employees in all categories and adequate space in which to perform its multitudinous functions and responsibilities. In fact, it is shown that all of our present difficulties derive from shortages of personnel and space, and if the war continues as estimated needs in these respects will be doubled.

This factual report is submitted for your information and such use as you may deem it merits. No recommendation is made, as advice has been received from the Bureau of the Budget that the bill is not in accord with the program of the President.

The CHAIRMAN. May I have that letter, General?

General HINES. Yes, Mr. Chairman. In all fairness, I suggest there be included a letter from Mr. Mitchell, President of the Civil Service Commission to Senator Johnson regarding H. R. 3118.

(The letter follows:)

UNITED STATES CIVIL SERVICE COMMISSION,  
Washington, D. C., June 15, 1945.

Hon. EDWIN C. JOHNSON,  
*United States Senate.*

DEAR SENATOR JOHNSON: The Commission's attention has been directed to the provisions in your bill, S. 971, to amend section 100 of Public Law 346, Seventy-eighth Congress, June 22, 1944, to grant certain priorities to the Veterans' Administration insofar as personal matters are concerned. It has done everything it possibly can to place all of its resources at the disposal of the Veterans' Administration and to see to it that those resources are pooled with the resources which the Veterans' Administration has available for recruiting purposes.

If the bill as proposed should become law, it would have the effect of removing positions in the Veterans' Administration from the classified service for the dura-



tion of the war. Consequently, the Civil Service Commission would be unable to utilize its resources in an effort to assist the Veterans' Administration in meeting its personnel needs. It is clear that this would have the effect of retarding rather than facilitating the filling of vacancies in the Veterans' Administration.

Unless it is desired to circumvent the provisions of the Veterans' Preference Act of 1944 by this bill, it will not introduce any more flexibility into the recruiting program of the Veterans' Administration than exists now under the war service regulations. All war agencies have been staffed without recourse to legislation of this kind.

The provision of the bill which would authorize the Veterans' Administration to hire persons at the maximum rather than the minimum of the schedule for a particular grade under the Classification Act is an example of the kind of a piecemeal approach to pay matters which gives to one agency of the Federal Government an unfair advantage over the other agencies of Government. If such legislation should pass, it would be difficult for Government, as an employer, to explain to an employee in one agency why that employee, although placed in the same grade as an employee in the Veterans' Administration, is, nevertheless, receiving less pay. Important as the duties and responsibilities of the Veterans' Administration are, there are other agencies of Government which are likewise discharging important responsibilities.

The Senate has just passed, and there is now pending before the House of Representatives, a pay bill which, if passed by the Congress and approved by the President, will improve the pay structures of the entire Government. It is clear that any other approach to a problem of this nature is unsound and unfair.

Measures such as those proposed in this bill never provide a real solution for personnel problems. The Commission believes that more can be done than has been done in the direction of delegating authority to act in connection with personnel problems to field officers of the Veterans' Administration, in the direction of giving the field administrative officers of the Veterans' Administration staff help in the personnel field, in the direction of providing better housing conditions for persons required to live at veterans' facilities, and in the direction of providing more adequate transportation facilities for persons who are required to travel a considerable distance in order to work at the veterans' facilities.

Two bills have been introduced, S. 971, your bill, and H. R. 3118, the bill which passed the House Monday. As explained in the above, it is the Commission's view that this proposed legislation is unnecessary and undesirable, and it urges that the bill be not given favorable consideration.

The Bureau of the Budget advises there is no objection to the presentation of this report as the enactment of the legislation as introduced in S. 971 and the companion bill, H. R. 3118, would not be in accord with the program of the President.

By direction of the Commission.

Very sincerely,

HARRY B. MITCHELL, *President.*

Mr. ALLEN. May I ask you, do you have any idea how long it would take you to get enough personnel to adequately take care of the situation?

General HINES. How long it would take?

Mr. ALLEN. Yes. When could we expect to have enough personnel, medical and otherwise, in our veterans' facilities to adequately take care of the situation?

General HINES. On the medical personnel, Congressman, I doubt very much whether we will be able to get the type of doctors we would like to have as a permanent set-up—I am speaking of that now—until there has been a larger demobilization than contemplated in the present year. The Surgeon General of the Army did indicate a number of these men are coming out, but the tendency of the best of that group, unless some special inducement is offered, would be to go to private practice, where there is a great shortage of doctors.

Mr. ALLEN. In other words, we will not get as many doctors as we need until after the war?

General HINES. I would say you will not get them until after the force selected to serve in Japan is selected and the rest demobilized.

The recruitment of nurses by the Army and Navy has stopped and we are getting some nurses now. We have over 500 cadet nurses training on our hospitals. We will get a fair proportion of those.

Mr. ALLEN. How are we going to get them, even after they select all they need to go to the Pacific war, because those who are not selected for that may insist on being separated from the service, and of course, when they go into private practice—and the practice is good now, and the returns good—and most of the physicians probably won't take the pay schedule of the Veteran's Administration.

General HINES. I have the feeling that if you pass the bill in some such form as I presented here, which offers permanency, retirement features, a better rate of pay than normal, for the young man particularly, I feel sure you will start to build a permanent medical service that will be satisfactory. That takes in not only doctors, it takes in nurses, dieticians, technicians of all kinds, it also embraces the administrative set-up to take care of one thing you have heard a good deal about during this investigation, and that is paper work that may be taken off the shoulders of nurses and doctors.

Mr. ALLEN. Will you answer this question: Do you feel we will ever be able to adequately staff our hospitals with medical help and so forth under the present civil-service set-up?

General HINES. I do not. When I came into the Bureau in 1923, not all of the positions were classified. I endeavored to get them all covered. I think every position is covered in the Veterans' Administration now except my own. But having gone through the experience we have, I wouldn't suggest that we take a chance, even in peacetime, of relying on Civil Service for your professional personnel.

Mr. PICKETT. As I understand the situation, you are relegated to the employment of your professional service from personnel recruited through Civil Service entirely, and paid upon civil-service rates.

General HINES. That is right.

Mr. PICKETT. And you have no alternative whatsoever to select personnel other than by that means?

General HINES. Only what they grant me, when they grant authority to recruit certain types.

Mr. PICKETT. I would like to ask another question. You referred to a discussion you had some time ago with a gentleman who took the position that you already had a sufficient number, and even an oversupply of doctors and nurses. You referred to the fact that no doubt he took that position because he had in mind the relationship of the number of patients to doctors in private hospitals. Did he give any other reason than that?

General HINES. No other reason. It was his conviction, and I am not sure that I convinced him at all that he was incorrect. But I may say, as a result of that meeting, we got a greater cooperation with the Procurement and Assignment Committee. But the difficulty was, Congressman, that the time for getting personnel had gone by. We were down pretty near to the bottom of the barrel on personnel. That is one of the great difficulties in this picture, as it grew from day to day. We all have better hindsight than foresight, and if I could have foreseen some of the other difficulties that were coming, I think you would have had a bill before this committee long before this time. It was a gradual growth, with the hope always that decisions would be made that would be helpful.



May I proceed to another matter that was raised in the committee?

Mr. SCRIVNER. Before you go on with that, I have two or three questions that this letter to Senator George raises in my mind. That is, you made the statement in there that the Veterans' Administration was unable to compete with other governmental agencies for help. Why aren't you able to compete?

General HINES. Well, we were not able to compete, in my judgment, because in the new agencies, built up, for some reason which I have been unable to determine, I think there was more liberal classification.

Mr. SCRIVNER. You indicate in this letter that persons in the Veterans' Administration performing the same types of duty as performed in other agencies were paid less than those in other agencies.

General HINES. That has been true. In some instances we found it so.

Mr. SCRIVNER. And yet you are all supposed to come under civil service, and the ratings are fixed by them.

General HINES. If I understand correctly, the Classification Act itself contemplates for the same duties, no matter where performed in the Government, the same classification will be given, no matter whether it is in the Veterans' Administration or anywhere else.

Mr. SCRIVNER. That is what I assumed, but, as I say, I have heard several times that one reason you can't get your help is because in Veterans' Administration they got paid less than in other agencies.

General HINES. In some instances that can be shown. But I think the difficulty is, to do a good classification job requires a great deal of time, and we don't get that time during a war, and new agencies, working under emergency, if the head of that agency says "We need so many stenographers in grade 3," when we are taking them in our jobs in grade 2, or they even want them in grade 4, they get them.

Mr. SCRIVNER. Why can't the Veterans' Administration do the same thing?

General HINES. We have done the same thing and tried to get them, but couldn't.

Mr. SCRIVNER. Did you have any luck?

General HINES. No.

Mr. SCRIVNER. Did you ever come to this committee and ask for any help, outside of this readjustment —

General HINES. No, I didn't come to this committee. I thought I could do it administratively.

Mr. SCRIVNER. When you couldn't get it, why didn't you come to this committee? My recollection is—while I have been on the committee only 18 or 19 months—my recollection over the history of years is that this committee has never denied the Veterans' Administration anything that would help them function properly.

General HINES. I think you are right. I think we made every effort that could reasonably be expected, except to appeal to Congress. That is, prior to the time we did appeal.

The CHAIRMAN. The Administrator of Veterans' Affairs, being under an executive department, I wonder if he hesitated coming to Congress for that reason.

General HINES. Well, Mr. Chairman, that letter illustrates one reason. The request for the legislation did not meet with the approval of the Budget or, it is stated, of the President, when I did come. I may say that I am one of those who will exert every possible effort



not to present to the Congress a problem that does not meet with the approval of the Budget and the President.

Mr. SCRIVNER. Haven't you found that at some time the Budget might possibly have been in error in some of their opinions?

General HINES. Yes, I have found it many times.

Mr. GIBSON. That doesn't change the fact that you didn't feel it your duty to go over their heads?

General HINES. No, I didn't think it would be proper, administratively. I think my efforts were devoted, and the records will show, to meeting with the Civil Service Commission and presenting the facts, urging the Budget. There is plenty of correspondence here which, if the committee desires, I can put in the record on all of the contentions made in that letter. Do you have other questions?

Mr. SCRIVNER. I have a series of them, but you say you want to go on to something else.

Mr. ALLEN. We want to remedy that situation. We don't want it to exist in the future. We want the head of the Veterans' Administration to feel he has more liberty. What suggestions do you have?

General HINES. Well, you passed a piece of legislation, although it is a year and eleven days old now, which made the Veterans' Administration a war agency. You attempted to amend it; you got some results. I believe it would be advisable to go all the way and adopt what you originally reported out of this committee. It may require presenting it to the Civil Service Committee in the Senate, but I do feel that the authority asked in that act which you passed and reported so promptly out of this committee is essential.

The CHAIRMAN. You mean the ones taken out by the Senate?

General HINES. That is right.

The CHAIRMAN. Now, gentlemen, on this proposition of the Administrator of Veterans' Affairs coming to the committee and asking for things, of course, it is highly improbable in a representative government for the executive departments to formulate the legislative program. We will all accept that. Besides, there are 435 Members of the House and 96 Senators who are supposed to look out for the legislative program. There are at least four recognized veterans' organizations, with representatives in practically every community in the United States, that also have this matter for their purpose.

General HINES. That is correct.

The CHAIRMAN. Also some auxiliary organizations, the Red Cross and other similar agencies, to help look out for and suggest necessary legislation.

General HINES. Yes.

The CHAIRMAN. Now, so far as I am individually concerned, I have always very much preferred to have legislation that was deemed necessary checked over by these various organizations and recommended to the committee. Sometimes I have found the Veterans' Administration, as the result of the attitude of the Bureau of the Budget and the Administration, generally, was not in a position to support provisions of the legislation recommended. Some of that legislation has been passed, and some of it, I think, passed over a veto, with my help. So it cannot altogether be attributed to the Administrator of Veterans' Affairs, the fact that we should have had additional legislation, especially if our foresight had been as good as our hindsight. I will say to the gentleman from Kansas that I don't think the fact

that we haven't had the necessary legislation can be laid at the door of the General.

Mr. SCRIVNER. Yes; but who knows better than the Administrator of Veterans' Affairs what is needed to correct the troubles he has been having? You cannot expect the veterans' organizations to know what troubles he is having in his department because they don't have that information available.

The CHAIRMAN. Any time any legislation is under consideration we would have summoned the Administrator of Veterans' Affairs before this committee.

Mr. SCRIVNER. That is right, because he is the one man who knows the answers.

The CHAIRMAN. The Member from Kansas knows very well that last year the legislation we passed did not come from the Veterans' Administration. It was proposed by some of the veterans' organizations, and some of the things in there I am sure did not meet with the approval of the Veterans' Administration, and I can understand why.

Mr. GIBSON. There is one other thing I can say to the gentleman from Kansas. He doesn't appreciate the power of the Bureau of the Budget.

Mr. SCRIVNER. How do I know when the Bureau of the Budget overrules something he asks for? We don't know what is happening down in his Administration unless he tells us about it.

Mr. GIBSON. Well, if the gentleman from Kansas does not like the—

Mr. SCRIVNER. Oh, I happen to be a member of the minority party, and there are a lot of things I don't like, including the troubles he had with Manpower, and the WPB, and the ODT—

The CHAIRMAN. Wait a minute. In that connection, let me say to the gentleman from Kansas that we had exactly the same trouble when his party was in power, and his party created the Bureau of the Budget over my protest.

Mr. SCRIVNER. The Bureau of the Budget has made some mistakes—yes. But they have done some good things, too.

The CHAIRMAN. I will say to the gentleman from Kansas that I sometimes make mistakes myself.

Mr. SCRIVNER. I am not astounded that you make mistakes, but I am astounded that you admit it.

Mr. ENGLE. I don't see how General Hines can be criticized for not coming up and speaking about the situation, when, of necessity, and under the rules, he must clear it through the Bureau of the Budget, and on which they, in effect, have the utmost control. I have seen that happen time and again, not only with his department, but others, where I know the administrators of the department wanted to come up here and support legislation, but the "doctors" down there in the Department said no, and that was the end of it.

Mr. SCRIVNER. And I have seen Congress say, "We don't care what you say about it; this is going to be the law."

Mr. ENGLE. But General Hines can't say that, we can.

General HINES. The gentleman from Kansas is fair-minded, and I think possibly, as I stated a while ago, I am not asking to have the thing laid upon the Bureau of the Budget or anybody else, on the question of the exercise of judgment. If I didn't come to the committee soon enough, then the job grew a little too fast, and we should



keep in mind, in all fairness, that this increased work of the Veterans' Administration came in a great hurry, that it came when we could not remedy it, and the best evidence that the Congress would probably have had difficulty, is shown by what happened with the legislation you reported out.

The CHAIRMAN. Gentlemen, I want to call attention to one other thing; in the last few years it has been my privilege to work out and get passed legislation for World War veterans. I know I have had the full cooperation of General Hines, the Administrator of Veterans' Affairs, and through him we have gone to the Chief Executive and got the approval of the Chief Executive before we consulted the Bureau of the Budget. I know many times General Hines has consulted with me about legislation that ought to be passed for the benefit of our disabled veterans and their dependents, and that legislation probably would not have gone through if it had not been for his efforts.

General HINES. Mr. Chairman, the very fact that the legislation I have proposed, and I mean proposed with you, as to a Bureau of Medicine and Surgery, was presented to this committee without a clearance from the Bureau of the Budget, but simply because the President gave his O. K. to it. You were present and heard me ask his permission to present it to the committee.

The CHAIRMAN. Yes; and I heard him give his O. K.

General HINES. And I also indicated, if you will recall, when you brought out this legislation to amend section 100—

The CHAIRMAN. Right in that connection, General Hines, I am sure if you had not taken the course you did and gone direct to the President, but had waited for clearance through the Bureau of the Budget, I am sure you would have got nowhere at all with that legislation.

General HINES. I am quite confident of that.

Now, can I go on to another personnel matter?

The CHAIRMAN. Yes.

General HINES. I believe that some question was raised as to whether the Medical Director of the Veterans' Administration was too far away from the Administrator, and in that way he was handicapped in his duties. The Medical Director has testified and he has answered your questions, and he has indicated that no interference has been given. We have had some discussion as to the advisability of lay managers or medical managers, but I would like to call the committee's attention to one order setting up the Veterans' Administration. The first order followed along on July 1, 1931. The language I am now going to read to the committee has been the same from that date up to the last revision in November 1944:

The medical and hospital service shall be under a Medical Director, who shall report to the Administrator, through an Assistant Administrator, and be responsible for the proper conduct of all activities under his charge. The Medical Director shall have jurisdiction over and be solely responsible for all medical and dental service rendered claimants and beneficiaries entitled thereto under the laws and regulations governing the operation of the Veterans' Administration, and rendered under due authority on behalf of other Federal agencies and foreign governments. Such services comprehend medical and dental treatment and care for hospitalized patients, including ill or injured domiciliary beneficiaries and for out-patients rendered at field stations or in homes of entitled beneficiaries and physical and laboratory examinations for adjudication of or for medical-treatment purposes.



It then goes on and outlines the organization set up. I think that Colonel Ijams pointed out to the committee that the Medical Director of the Veterans' Administration is really, in fact, not so far away from the head of that agency as we have in the situation of the Surgeons General of the Army and the Navy.

Naturally somebody is going to ask you why I have never appointed the Medical Director an Assistant Administrator. My answer is simply this, the activities of the medical service, with the supply service and the construction service require the closest coordination. The Assistant Administrator acts in my place wherever he is assigned. He acts there simply to coordinate the activities of the services placed under him. He acts under the delegation of authority in those matters which are delegated to him. He acts for the Administrator. Several times recommendations have been made that the Medical Director be made an Assistant Administrator. I have not seen fit, up to this time, to change the present set-up. It has functioned. I have not found any interference which if removed would enable him to function better.

But I would say in all fairness to the committee, in the bill it is contemplated, for the purpose of increasing the pay of that office, which is going to double many times in responsibilities and duties, due to the large number of men coming from World War 2, that the picture in dealing with the problems of World War 2, are going to require a man in that position who should, in my judgment, be paid a much higher salary than under the present classification.

But if you will go back to when we entered this war, you will find that you had very few complaints of operation of the hospitals. You heard very little about the Veterans' Administration, because the work had gone to the point where we were over the peak. Coupled with that is the fact that we consolidate regional offices with hospitals and homes. They all tie in to one thought: the peak of the work of World War I, in claims, in examinations—mind you, more than 3,000,000 men have gone through these hospitals—was over. If we could have maintained our staff, our well-trained attendants, many of these things that have been complained of would never have occurred.

There isn't any function that is as important, in looking to the future, than the training of the personnel and the keeping of your personnel in these institutions. In other words, we had abuses, yes; accidents in those hospitals. They all have them. You will never get a correct picture until you can make some comparisons of the Veterans' Administration's psychopathic hospitals with those of the States and other institutions. The attendant group must be a permanent group, well trained in how to handle these patients, or you will have more accidents.

I find in looking back over my records, that as far back as 1935, due to the fact that reports on the treatment of patients in psychopathic hospitals seemed to be getting more frequent, that I asked the Superintendent of St. Elizabeths Hospital to give me, on detail, a well-trained attendant that could be sent to some of these institutions and be hired as any other attendant and report what took place in the badly disturbed wards. Such a man was detailed; his name was Lawrence S. Taylor, from St. Elizabeths. I sent him to Fort Lyon, Colo., on June 17, 1935. He submitted a report; he left our employ and went back to St. Elizabeths in August. He was unable to find very much wrong.

At that time we had very well-trained attendants. Now we haven't well-trained attendants. They are trained, they are carefully instructed, but they are human, and they are not trained well enough—the turn-over is too great—and I cannot conceive that the personnel detailed from the Army and Navy find the duties congenial to them.

So, to my mind, one of the most important personnel problems is the establishment, as early as you can, at whatever pay scales may be necessary, of an attendant group. The turn-over in that group must not occur often. If it does, you are going to have accidents. Mind you, it is not all abuse. The attendants can only do those things that they are on the job and see. Patients, among themselves, do more damage to each other than any attendant would ever do. They require most careful attention, those who are badly disturbed, at certain periods. These abuses run all the way from a slap to some way to control the patient. Unless the attendant knows how to control a patient, he is apt to injure him and the patient would injure himself or someone else, so that I would urge the committee to do everything possible to find a way, and the way is to pay adequate salaries to carefully selected men in the various communities. Now, the pay scale has got to be flexible enough so that in a given area, where an institution is, you are able to hire people who can qualify for such work.

The CHAIRMAN. General, can you be back at 1:30?

General HINES. Yes, sir.

The CHAIRMAN. Will that suit you?

General HINES. That is all right.

The CHAIRMAN. Very well; the committee will return at 1:30.

(Whereupon, at 11:45 a. m., the committee adjourned to 1:30 p. m.)

#### AFTERNOON SESSION

The CHAIRMAN. The committee will come to order. General Hines, are you ready to proceed?

General HINES. Yes, sir. Mr. Chairman and members of the committee, when you recessed I was dwelling upon the treatment of patients in psychopathic hospitals. The committee has requested a statement showing action taken in those cases where we had evidence dealing with the defendants, and the charge, and the action taken by the Department of Justice. We have a statement here that goes back to 1925, and up to 1945, which I would like to introduce in the record, if I may.

The CHAIRMAN. Without objection, it is so ordered.

(The statement referred to is as follows:)

Office memorandum, United States Government.

To: Mr. Hughes, Assistant Solicitor.

From: H. L. Jones.

Subject: Assaults by attendants upon patients in NP hospitals of the Administration.

The records of this Office relative to prosecutions have been reviewed to ascertain the action taken in cases of abuse of patients in our neuropsychiatric hospitals. The records available for this study cover two periods. For the period from 1925 to May 1, 1939, there is available a report made on May 1, 1939, in connection with a general survey of the Office covering all classes and types of cases referred to the Department of Justice. The other is a series of record cards made upon each submission to the Department, the earliest of which is dated October 6, 1936, when this system of records was adopted. Since the later date it appears this

Office has submitted evidence to the Department of Justice for consideration as to possible prosecution of the cases of 58 attendants for abuse of patients in neuro-psychiatric hospitals. One case is now pending completion of the investigation. During the period since October 6, 1936, 6 instances (involving 8 attendants) were called to the attention of this Office in which submissions to the Department of Justice were not in order. (List attached which shows reasons for not submitting.) The cases involving the 58 attendants which were submitted to the Department of Justice were disposed of as follows:

Closed without prosecution.....	29
Convictions.....	6
Acquittals.....	2
Grand jury failed to indict.....	5
Pending.....	16

The report made by this Office covering the period from 1925 to May 1, 1939, shows that during the 14 years covered by it, 19 cases were submitted to the Department of Justice for violation of section 455, title 18, United States Code, that is, for assault. Of these 19, the Department of Justice closed 6 without action and submitted 13 to the grand jury with the result that 11 indictments were returned. In the 2 other cases the submissions were ignored. Of the 11 indictments, 3 were later dismissed and in 8 cases the defendants were found guilty.

It will be noted that in the 14 years ending May 1, 1939, there were but 19 assault cases altogether including the first 4 included in the period covered by this report whereas since 1939 there have been 51 cases. For example, in 1940 evidence against two attendants was submitted. In 1941, 4 cases were submitted to the Department of Justice. In 1942, there were 8 submissions in which 8 attendants were involved. In 1943 this Office received 13 such cases and made 10 submissions. In 1944, 9 cases were received by this Office and 8 submissions involving 10 attendants were made to the Department of Justice. Up until today (1945), 8 cases of assaults involving 19 attendants have been referred to this Office and evidence in which 17 attendants were involved has been transmitted to the Department of Justice. This summary indicates that the number of such cases has increased materially beginning with the year 1942 which is the period during which there has been a shortage of physicians, nurses, and attendants and during which there has been an increase in the number of patients.

#### ASSAULTS OR FIGHTS BETWEEN PATIENTS

There have been a considerable number of submissions to the Department of Justice wherein there was evidence indicating difficulty between patients or members of the domiciliary facilities. Their cases have not been included in the report submitted except those which may be among the 19 cases submitted to the Department of Justice in years preceding May 1, 1939.

#### ASSAULTS BY PATIENTS, DEATH OR INJURY TO EMPLOYEES, ETC.

There are also attached for your convenience two tables; one shows those cases in which persons, patients, attendants, or physicians lost their lives, and the other table shows assaults by patients upon employees or others wherein there was no loss of life and which were submitted for prosecution by the United States attorneys.

HARRY L. JONES.



*Assaults by attendants upon patients submitted to Department of Justice*

Received	Facility	Defendants	Charge	Action taken by Department of Justice
Oct. 6, 1936	Roanoke, Va.	Zimmerman, John; Lockart, Dave.	Assault, 18 U. S. C. 455.	No prosecution.
Feb. 14, 1937	American Lake, Wash.	Deneva, Gustave	do	Do.
Aug. 21, 1937	Indianapolis, Ind.	Karchner, Loren	do	Convicted.
Aug. 31, 1938	Roanoke, Va.	Rickard, Carl E.; McKinley, Anderson; Skalski, J. J.	do	No prosecution.
Nov. 19, 1940	Los Angeles, Calif.	Burnett, Felix W.; Brown, Robert G.	do	Convicted.
May 8, 1941	St. Cloud, Minn.	Nelson, Clifford T.	do	Convicted; 90 days.
Oct. 24, 1941	Roseburg, Oreg.	Dirks, Howard C.	do	No prosecution.
Dec. 4, 1941	Perry Point, Md.	Kenney, George H.	do	Do.
Dec. 31, 1941	Dayton, Ohio	Tootle, Hoyt G.	do	No bill.
Jan. 1, 1942	Tuskegee, Ala.	Reid, Obie D.	do	Acquitted.
Apr. 14, 1942	Dayton, Ohio	Scott, Elbert; Francke, David E.	do	No prosecution.
May 5, 1942	Murfreesboro, Tenn.	Mills, Orel	do	Do.
Sept. 5, 1942	Roanoke, Va.	Holcomb, Thomas R.	do	Acquitted.
Oct. 9, 1942	Perry Point, Md.	Evans, Leon S.	do	No prosecution.
Oct. 13, 1942	Fort Lyons, Colo.	Lane, James A.	do	Do.
Nov. 27, 1942	Lyons, N. J.	Cole, John F.	do	Do.
April 3, 1943	Coatesville, Pa.	Nelson, Clifford	do	Do.
April 5, 1943	do	Ostrowski, Lawrence	do	Do.
April 26, 1943	Fort Lyons, Colo.	Barlow, Warren J.	do	Convicted - 5 months.
May 21, 1943	Lexington, Ky.	Littrell, Eddie	do	No prosecution
July 10, 1943	Canandaigua, N. Y.	Thompson, Elmer F.	do	Do.
Oct. 9, 1943	Los Angeles, Calif.	Peacock, Joseph V.	do	Do.
Nov. 12, 1943	Bedford, Mass.	Bragan, George L.	do	No bill.
Nov. 15, 1943	Roanoke, Va.	Moore, William G.	do	Convicted; 2 year suspended.
Dec. 10, 1943	Murfreesboro, Tenn.	Davenport, Clarence	do	No prosecution;
Dec. 19, 1943	Lexington, Ky.	Curtis, Arthur G.	do	Do.
Feb. 19, 1944	Lyons, N. J.	Kosciuk, E. P.; Sheehan, Thomas.	do	No bill.
May 11, 1944	Wadsworth, Kans.	Evans, John R.	do	Do.
May 26, 1944	Dayton-Ohio	Riley, Harry L.	do	Pending.
July 1, 1944	Tuskegee, Ala.	Kurtz, John H.	do	No prosecution.
Aug. 22, 1944	American Lake, Wash.	Rogers, David M.; Bredendbach, L. H.	do	Do.
Aug. 29, 1944	Wadsworth, Kans.	Haynes, William J.	do	Do.
Nov. 4, 1944	Fort Custer, Mich.	Danks, Chris	do	Pending.
Nov. 28, 1944	do	Birmingham, Ralph V.	do	Do.
Jan. 16, 1945	St. Cloud, Minn.	Attendants (names not known).	do	Do.
Mar. 14, 1945	Lyons, N. J.	Weisshaar, Milton	Assault, manslaughter.	Do.

## SENT TO UNITED STATES ATTORNEY

Apr. 5, 1945	Downey, Ill.	Gotowtis, John; Flannigan, John	Assault, 18 U. S. C. 455.	Pending.
Do	Coatesville, Pa.	Kimley, Edward	do	Do.
May 24, 1945	Perry Point, Md.	Evans, Vivian P.; Lowe, Gordon K.; Sells, Charles A.; Voderey, Harry.	do	No prosecution.
May 31, 1945	Northport, N. Y.	Griffin, Emet J.; Ly-singer, Robert B.; Schuh, Edward J.; Stelljes, Henry; Holzworth, George; Wat-son, William J.; Kas-tik, Eric.	do	Pending.
June 5, 1945	Tuskegee, Ala.	Sturgeon, Frank	do	Do.
May 5, 1945	Augusta, Ga.	Attendants Carter, Crocker.		This case is now being inquired into by a central office investiga-tor.

*Cases not submitted to Department of Justice*

Received	Facility	Attendant	
July 30, 1943	Roanoke, Va.....	Paugh, Clarence O....	Manager recommended reprimand; he did not strike patient Ellis Dunk, C-2782652; was rough in trying to quiet him. No submission to Department of Justice.
Nov. 29, 1943	Marion, Ind.....	Blackman, Herman A....	Rough in handling patient William G. White, C-2282800; 2 weeks' suspension; transfer recommended by committee. No submission to Department of Justice.
Mar. 17, 1943	Fort Lyon, Colo.....	Stuart, John R.....	Rough handling of patient John J. Davis, C-2905103; examined by two physicians; no evidence of injury found. Separated; no submission to Department of Justice.
Feb. 21, 1944	Chillicothe, Ohio.....	Sams, Elga.....	Board of investigation was of opinion Sams was implicated in incident injuring patient Arthur L. Fannin, C-1154480 and was "too rough in his handling of patient" Marshall Hayes, C-1806593 and recommended his discharge. Manager reports Sams "was dropped * * * as a result of unauthorized absence." No witnesses to rough handling of patients. No submission to Department of Justice.
May 2, 1944	St. Cloud, Minn.....	Patsch, Joseph; Matz, Joseph E.; Hoeft, Martin E.	Preliminary report referred to this office by Mr. Hiller for comment and returned to him with suggestion that while a submission to the Department of Justice appeared indicated further investigation and administrative action should first be completed. Case never submitted for this office for prosecutive action.
Feb. 8, 1945	Lyons, N. J.....	Schleur, Stephen C....	NOTE.—Patsch resigned, others reprimanded. Board of inquiry made report; attendant not separated from rolls, no submission made.

*Deaths resulting from assaults by patients or beneficiaries*

Date	Facility	Assailant	Victims	Disposition of case
Aug. 20, 1936	Dayton, Ohio.....	Schaeffter, Sylvester.	Dr. E. M. Clark.....	Committed to Ohio State Hospital for Criminal Insane, Lima, Ohio.
June 29, 1933	---do.....	Shadbolt, James.	Col. Vernon Roberts, M. D.	Do.
Aug. 20, 1937	Bedford, Mass.....	Hunt, Bertram.....	John A. Sullivan, patient.	Reported to United States attorney; no action; insane.
May 24, 1939	Perry Point, Md..	Jacksetic, Mike...	Geo. W. Hutchins, patient.	Do.
Aug. 23, 1939	Canandaigua, N. Y.	Ward, Leroy.....	William J. Holman, attendant.	Reported to United States attorney; committed by United States court to St. Elizabeths.
Oct. 30, 1939	Mount Alto, District of Columbia.	Cassell, Frank.....	Dr. Amoine.....	Do.
Oct. 16, 1939	Wadsworth, Kans.	Epps, Obie.....	Another member of home.	Convicted; sentence 30 years.
Apr. 16, 1941	St. Cloud, Minn..	Beleal, Roy.....	Chester Mitchell, patient.	Defendant insane; no prosecution.
Aug. 3, 1936	Hines, Ill.....	Davis, Gilbert....	James Wright, patient.	Convicted; 8 years.
Nov. 23, 1936	Los Angeles, Calif.	Boydson, Walter R.	Ransom P. Ham, member.	Convicted; 15 years.

*Other assaults by patients or beneficiaries reported to Department of Justice*

Received	Facility	Defendants	Victims	Disposition
Jan. 14, 1936---	Tucson, Ariz.-----	Popoff, Peter-----	Mrs. E. Hastings, nurse.	Convicted; 4 years.
July 14, 1936---	Phoenix, Ariz.-----	Kane, Frank-----	Dr. J. J. Beatty-----	Convicted; 10 years.
July 1, 1938---	Togus, Maine-----	Budniak, Joseph--	Guards	Convicted; 4 months.
Jan. 11, 1940---	Los Angeles, Calif	Allen, Bob-----	Roger Moss, member	Convicted; 15 months.
Sept. 10, 1940---	Kecoughtan, Va--	Calvert, Robert---	Dr. E. E. Zimmerman	Convicted; 6 months (suspended).
July 24, 1944---	Los Angeles, Calif	Holmes, Lauret---	Marguerite Burns-----	Convicted (probation 18 months).
Mar. 27, 1945---	Muskogee, Okla--	Byrd, Slayton-----	L. L. Malsed, adjust- ment officer.	Pending.
May 21, 1945---	Montgomery, Ala.	Kendrick, Warner	C. J. L. Frazier, DAV representative.	Do.
1945-----	Hines, Ill.-----	Triplett, Robert--	Patient-----	Guilty; 2 years.



Section	Remarks	Sub- mitted	Closed by De- part- ment of Justice	To grand jury	Action by grand jury		Action on indictments		
					No bills	In- dictments	Nol pros	Guilty	Not guilty
District of Columbia Code.....	Criminal libel.....	1	1						
54, title 18 United States Code.....	Conspiring to prevent officer from performing duties.....	3	2	1		1	1		
71, title 18 United States Code.....	Forgery of patents.....	2	1	1		1		1	
72, title 18 United States Code.....	Forging or altering bond, bids or public records.....	3	2	1		1	1		
73, title 18 United States Code.....	Forging or altering mail and transportation requests.....	34	5	29	7	22	3	16	3
75, title 18 United States Code.....	Officer making false acknowledgments.....	1	1						
76, title 18 United States Code.....	Impersonating United States officer.....	29	1	21	2	19	3	16	
80, title 18 United States Code.....	Presenting false claims.....	327	109	218	67	151	31	117	3
81, title 18 United States Code.....	Making and presenting false papers re pensions.....	2	15	17	5	12	3	9	
82, title 18 United States Code.....	Stealing personal property of United States.....	1	1	1		1		1	
88, title 18 United States Code.....	Conspiracy to defraud United States.....	46	18	28	8	20	2	15	3
91, title 18 United States Code.....	Bribery.....	9	3	6	1	5	2	3	
92, title 18 United States Code.....	Taking or using papers re claims.....	1		1		1		1	
99, title 18 United States Code.....	Robbing another of personal property of United States.....	2		2		2		2	
100, title 18 United States Code.....	Embezzling money or property of United States.....	31	9	22	7	15	3	11	1
101, title 18 United States Code.....	Receiving stolen public property.....	1		1		1		1	
136, title 18 United States Code.....	Forging and using discharge certificate.....	4	1	3	1	2		2	
150, title 18 United States Code.....	Receiving money for appointment to office.....	3	3						
183, title 18 United States Code.....	Embezzling public money by officer.....	7		7	1	6		6	
231, title 18 United States Code.....	Perjury (witnesses in insurance suits).....	15	6	9	2	7	3	4	
232, title 18 United States Code.....	Subornation of perjury.....	2	1	1		1		1	
234, title 18 United States Code.....	Destruction of United States records.....	6		6		6	1	5	
235, title 18 United States Code.....	Destruction of United States records by officer.....	2		2	1	1		1	
245, title 18 United States Code.....	Assaulting officer.....	1	1						
338a title 18 United States Code.....	Use of mails to defraud.....	2	1	1		1		1	
445, title 18 United States Code.....	Obstructing enforcement of law.....	1	1						
452, title 18 United States Code.....	Murder (on reservations).....	3		3		3		2	1
453, title 18 United States Code.....	Manslaughter (on reservations).....	2	1	1		1		1	
455, title 18 United States Code.....	Assault (on reservations).....	19	6	13	2	11	3	8	
466, title 18 United States Code.....	Larceny (on reservations).....	1	3	3		3		3	
468, title 18 United States Code.....	Prosecutions under State laws in United States court.....	3	1	2		2		2	
309, World War Adjusted Com- pensation Act.....		354	179	175	39	136	21	102	13
500, World War Veterans' Act.....	Attorney fees.....	530	242	288	86	202	42	141	19
114, title 38 United States Code.....		65	34	31	8	23	7	14	2
202, Public, 844.....		19	12	7	3	4		4	
503, World War Adjusted Com- pensation Act.....	Unlawful loans on certificate as security.....	24	11	13	4	9	1	7	

702, World War Adjusted Com- pensation Act.....	False statements in applications, etc.....	187	93	94	22	72	13	58	1
501, World War Veterans' Act.....	False statement under oath in pension claim, etc.....	221	73	148	33	115	39	65	11
12, Public, No. 2.....		53	23	30	5	25	1	24	
502, World War Veterans' Act.....	Receiving benefits after losing right to same.....	30	5	22	1	16	2	13	1
13, Public, No. 2.....		14	5	9	1	8	1	7	
503, World War Veterans' Act.....	Obtaining benefits—defrauding United States or bene- ficiary.....	229	110	119	23	96	34	55	7
14, Public, No. 2.....		33	14	19	3	16	1	14	1
504, World War Veterans' Act.....	False affidavits, etc. (forfeitures).....	252	103	148	35	115	19	72	22
15, Public, No. 2.....		112	45	67	17	50	7	40	3
127, title 38 United States Code.....	Embezzlements by guardians.....	44	19	25	7	18	2	15	1
505, World War Veterans' Act.....		419	150	200	51	218	45	161	12
16, Public, No. 2.....		84	33	51	7	44		43	1
2, Public, No. 262.....		90	38	52	6	46	1	43	2
Total.....		3,358	1,391	1,967	460	1,507	292	1,108	107

Percent of convictions based on submissions.....	33.3
Percent of indictments to submissions.....	44.8
Percent of convictions to indictments.....	73.4
Percent of convictions to cases called for trial.....	91.2

Mr. SCRIVNER. Could you give us what it shows, in substance?

General HINES. Well it shows that in 1936 we had one case of assault in which the Department of Justice did not prosecute. In part, it reads as follows:

The records of this office relative to prosecutions have been reviewed to ascertain the action taken in cases of abuse of patients in our neuropsychiatric hospitals. The records available for this study cover two periods. For the period from 1925 to May 1, 1939, there is available a report made on May 1, 1939, in connection with a general survey of the office covering all classes and types of cases referred to the Department of Justice. The other is a series of record cards made up on each submission to the Department, the earliest of which is dated October 6, 1936, which this system of records was adopted. Since the later date it appears this office has submitted evidence to the Department of Justice for consideration as to possible prosecution of the cases of 58 attendants for abuse of patients in neuropsychiatric hospitals. One case is now pending completion of the investigation. During the period since October 6, 1936, six instances (involving eight attendants) were called to the attention of this office in which submission to the Department of Justice was not in order. (List attached which shows reasons for not submitting.) The cases involving the 58 attendants which were submitted to the Department of Justice were disposed of as follows:

Closed without prosecution.....	29
Convictions.....	6
Acquittals.....	2
Grand jury failed to indict.....	5
Pending.....	16

The report made by this office covering the period from 1925 to May 1, 1939, shows that during the 14 years covered by it, 19 cases were submitted to the Department of Justice for violation of section 455, title 18, United States Code; that is, for assault. Of these 19 the Department of Justice closed 6 without action and submitted 13 to the grand jury with the result that 11 indictments were returned. In the 2 other cases the submissions were ignored. Of the 11 indictments 3 were later dismissed and in 2 cases the defendants were found guilty.

Mr. McQUEEN. Those 16, General, I presume, are the 16 that are now pending before the second district of New York?

General HINES. That is right, or elsewhere the report and charts may be placed in the record here.

I am convinced on that subject, and unless there is some question, I will take up some other matters. Even in normal times, and with well-trained personnel, it will be essential to make careful checks by undercover attendants. By that I mean men that can be hired as attendants, reach the acute wards, and submit their reports, upon which an investigator can get evidence.

Otherwise it is very difficult to get any admission under any other form of investigation.

The CHAIRMAN. General, you sent the undercover men to get this information, did you?

General HINES. That is right.

The CHAIRMAN. In other words, the undercover men were furnished by the Veterans' Administration in order to get this information?

General HINES. That is correct. And we have them operating right now, and we expect to continue that, because when these men leave a hospital, Mr. Chairman, the attendants do not know where they have gone. They go to another hospital and they are hired there as attendants. They render their reports. And then the investigator checks through their report. I know of no other effective means, and I am satisfied that the very fact that such undercover investigators are being used has a very good effect on the attendants generally.



Mr. McQUEEN. May I ask, General, when you assign undercover men to these hospitals, who knows about it besides your investigating department?

General HINES. We try not to have anybody else know about it. Once in a while the manager is taken into our confidence, but generally the best system is not to advise anybody.

Mr. McQUEEN. Not even the manager?

General HINES. No; just let him be hired and go on. It takes longer that way; it may take an attendant 60 to 90 days to get on the ward in which we can expect trouble. He may serve on other wards and find nothing. But I know of no more effective method than that.

The CHAIRMAN. General, if that same system were used in all the State and private mental hospitals, what kind of conditions would they reveal, in your opinion?

General HINES. Well I have no way of telling. Mr. Chairman, what the conditions are. The managers of our institutions, in areas where they are, seem to feel that we have less than the others, but I have no evidence on which I can testify.

The CHAIRMAN. I see.

General HINES. Some evidence, I think, can be obtained, if the committee desires, from the Governors of the various States.

Now, Mr. Chairman, I would like to take up the subject of managers of our institutions.

A question was raised as to the feasibility of operating a hospital with a lay manager, and the desirability of so doing. We have no objection to the assignment of a medical man as manager when he has demonstrated that he has the administrative ability to run such an institution. I do not feel that the present tendency, even in civilian institutions, large ones, is necessarily to have doctors as managers. We try, in our psychopathic hospitals to assign, wherever you can find one, a psychiatrist that is also a capable administrative doctor, to a straight neuropsychiatric hospital.

Our combined facilities have many activities that have nothing to do with the care of the patients. In those cases the chief medical officer and his clinical director have full charge of the medical activities.

The business management of those institutions, the large ones, is a great business undertaking and requires a businessman, in many instances, to run.

No manager with good common sense would attempt to dictate to the chief medical officer or the clinical director. Very few instances of conflict have occurred. However, I know that doctors, among themselves, feel strongly that a hospital, straight hospital, should be managed by a doctor.

I have here a list of the field stations of the Veterans' Administration, with the names of the managers. You will find that a large number of them—particularly the hospitals—are managed by doctors.

Combined facilities—where the activities include regional office facilities, that is the adjudication of claims, and so on—you will find that the majority of them are managed by laymen.

For the information of the committee I would like to place that list in the record.

The CHAIRMAN. Without objection, it is so ordered.



(The list referred to is as follows:)

*Field stations of Veterans' Administration, June 28, 1945*

<i>Location</i>	<i>Manager</i>
<b>Area offices:</b>	
Atlanta, Ga.....	Mr. Wilkes H. Davis.
Baltimore, Md.....	Mr. Edward A. Keck.
Boston, Mass.....	Mr. Frederick J. Shea.
Chicago, Ill.....	Mr. John P. Cullen.
Columbus, Ohio.....	Mr. Vester Garrett.
Dallas, Tex.....	Mr. S. P. Kohen.
New York, N. Y.....	Mr. Joseph F. O'Hern.
San Francisco, Calif.....	Mr. Manie C. Perryman.
St. Louis, Mo.....	Mr. Leon L. Leach.
<b>Insular offices:</b>	
Honolulu, T. H.....	Mr. Carl M. Walker.
Manila, P. I.....	Lt. Col. James C. Palmer.
San Juan, P. R.....	Maj. Jaime S. Chavarry (M. D.).
<b>Regional offices:</b>	
Albany, N. Y. <sup>1</sup> .....	Mr. Charles C. Adams.
Baltimore, Md.....	Mr. William L. Limburg.
Boston, Mass.....	Gen. William J. Blake.
Denver, Colo.....	Mr. A. D. Borden.
Jackson, Miss.....	Mr. W. S. Shipman.
Kansas City, Mo.....	Mr. John A. Brody.
Little Rock, Ark.....	Mr. James A. Winn.
Los Angeles, Calif.....	Col. L. C. Chapman.
Manchester, N. H.....	Mr. James J. Doyle.
Newark, N. J. <sup>1</sup> .....	Mr. Homer Rogers.
New Orleans, La.....	Mr. Frank Martinez, Jr. (acting).
New York, N. Y.....	Mr. E. B. Dunkleberger.
Philadelphia, Pa.....	Mr. H. J. Crosson.
Pittsburgh, Pa.....	Mr. Kenneth S. Covey.
Providence, R. I.....	Col. Davis G. Arnold.
Seattle, Wash.....	Mr. O. G. Fairburn.
Sious Falls, S. Dak.....	Mr. Charles B. Kaercher.
St. Louis, Mo.....	Mr. Edward J. Wieland.
Washington, D. C.....	Mr. Howard F. Dickensheets.
Wilkes-Barre, Pa.....	Mr. Michael B. Reap.
<b>Combined facilities:</b>	
Albuquerque, N. Mex.....	Mr. David K. Dalager.
Atlanta, Ga.....	Mr. J. M. Slaton, Jr.
Batavia, N. Y.....	Mr. C. F. Sargent.
Bay Pines, Fla.....	Mr. M. Bryson.
Boise, Idaho.....	Mr. C. H. Hudelson.
Brecksville, Ohio.....	Gen. William L. Marlin.
Cheyenne, Wyo.....	Mr. James L. Laughlin.
Columbia, S. C.....	Mr. S. C. Groeschel.
Dayton, Ohio.....	Mr. John H. Ale.
Dearborn, Mich.....	Mr. Guy F. Palmer.
Des Moines, Iowa.....	Mr. William B. Nugent.
Fargo, N. Dak.....	Mr. C. T. Hoverson.
Fayetteville, N. C.....	Mr. James S. Pittman.
Fort Harrison, Mont.....	Dr. Herbert C. Watts.
Hines, Ill.....	Mr. Charles G. Beck.
Huntington, W. Va.....	Mr. H. G. Hooks.
Indianapolis, Ind.....	Mr. B. C. Moore.
Lexington, Ky.....	Mr. Harry W. Farmer.
Lincoln, Nebr.....	Mr. E. R. Benke.
Los Angeles, Calif. <sup>2</sup> .....	Col. R. A. Bringham.
Lyons, N. J.....	Dr. Harold E. Foster.
Minneapolis, Minn.....	Mr. C. D. Hibbard.
Montgomery, Ala.....	Mr. M. E. Head.
Murfreesboro, Tenn.....	Mr. Sam Jared, Jr.

<sup>1</sup> In process of opening.

<sup>2</sup> Being changed to facility.

*Field stations of Veterans' Administration, June 28, 1945—Continued*

<i>Location</i>	<i>Manager</i>
<b>Combined facilities—Continued.</b>	
Muskogee, Okla.....	Mr. Polk T. Lundquest.
Newington, Conn.....	Mr. Myer Schwolsky.
Portland, Oreg.....	Lt. Col. Paul I. Carter (M. D.).
Reno, Nev.....	Mr. Edward F. Reed.
Roanoke, Va.....	Col. Edwin W. Jordan.
Salt Lake City, Utah.....	Mr. E. A. Littlefield.
San Francisco, Calif.....	Col. James G. Donnelly (M. D.).
Togus, Maine.....	Mr. M. L. Stoddard.
Tucson, Ariz.....	Col. William T. Hardaway.
Waco, Tex.....	Col. Harry Rubin (M. D.).
White River Junction, Vt.....	Col. L. C. Chapman. <sup>3</sup>
Wichita, Kans.....	Mr. Leonard N. Sowards.
Wood, Wis.....	Mr. Paul G. Froemming.
<b>Facilities:</b>	
Alexandria, La.....	Dr. Tarleton F. Moore.
Amarillo, Tex.....	Lt. Col. Oma E. Herndon (M. D.).
American Lake, Wash.....	Col. John G. Cullins (M. D.).
Aspinwall, Pa.....	Col. Kelso A. Carroll (M. D.).
Augusta, Ga.....	Dr. Henry O. Witten.
Bath, N. Y.....	Col. John A. Hadley.
Bedford, Mass.....	Dr. Winthrop Adams.
Biloxi, Miss.....	Mr. Eugene A. Hiller.
Bronx, N. Y.....	Col. Robert C. Cook (M. D.).
Canandaigua, N. Y.....	Dr. Hans Hansen.
Castle Point, N. Y.....	Col. Carleton Bates (M. D.).
Chillicothe, Ohio.....	Dr. Cecil B. Shrout.
Coatesville, Pa.....	Dr. Clarence R. Miller.
Dallas, Tex.....	Lt. Col. Charles L. Magruder (M. D.).
Danville, Ill.....	Dr. George A. Rowland.
Downey, Ill.....	Col. Delmar Goode (M. D.).
Dwight, Ill.....	Lt. Col. William E. Kendall (M. D.).
Excelsior Springs, Mo.....	Dr. Forest G. Bell.
Fayetteville, Ark.....	Dr. Frank N. Gordon.
Fort Bayard, N. Mex.....	Dr. Allen G. Fuller.
Fort Custer, Mich.....	Dr. Fogor P. Hentz.
Fort Howard, Md.....	Lt. Col. Warren L. Fleck (M. D.).
Fort Lyon, Colo.....	Dr. Victor H. Bean.
Fort Meade, S. Dak.....	Dr. Peter A. Pepper.
Fort Washington, Md.....	Col. William G. Stevens.
Gulfport, Miss.....	Col. Gettis T. Sheffield (M. D.).
Hot Springs, S. Dak.....	Mr. Robert R. Gibson.
Jefferson Barracks, Mo.....	Dr. Walter A. German.
Kecoughtan, Va.....	Col. Keith Ryan.
Knoxville, Iowa.....	Dr. Frederick S. Salisbury.
Lake City, Fla.....	Dr. Howard C. Von Dahm.
Legion, Tex.....	Dr. Carroll L. Moore.
Livermore, Calif.....	Lt. Col. Jesse J. Beatty (M. D.) acting.
Marion, Ill.....	Dr. Edward A. Welch.
Marion, Ind.....	Col. Harry H. Botts (M. D.)
Memphis, Tenn.....	Dr. H. C. Dodge.
Mendota, Wis.....	Lt. Col. Letcher E. Trent (M. D.).
Mountain Home, Tenn.....	Maj. David H. Taylor.
Northampton, Mass.....	Col. William M. Dobson (M. D.).
North Little Rock, Ark.....	Col. Duncan D. Campbell (M. D.).
Northport, Long Island, N. Y.....	Col. Louis F. Verdel (M. D.).
Oteen, N. C.....	Dr. Frank B. Brewer.
Outwood, Ky.....	Dr. Samuel H. James.
Palo Alto, Calif.....	Dr. P. G. Lasche.
Perry Point, Md.....	Col. Harry G. Clarke (M. D.).

<sup>3</sup>Being transferred to regional office at Los Angeles Calif

*Field stations of Veterans' Administration, June 28, 1945—Continued*

<i>Location</i>	<i>Manager</i>
<b>Facilities—Continued</b>	
Roseburg, Oreg.-----	Dr. George M. Melvin.
Rutland Heights, Mass.-----	Dr. John N. Wilson.
San Fernando, Calif.-----	Dr. David C. Farnsworth.
Saratoga Springs, N. Y.-----	Dr. John S. Walsh.
Sheridan, Wyo.-----	Dr. Harold W. Sterling.
St. Cloud, Minn.-----	Dr. John A. Pringle.
Sunmount, N. Y.-----	Col. Harold R. Lipscomb (M. D.).
Tuscaloosa, Ala.-----	Lt. Col. George L. Johnson (M. D.).
Tuskegee, Ala.-----	Col. Eugene H. Dibble, Jr., (M. D.).
Wadsworth, Kans.-----	Lt. Col. Frederick M. Cook (M. D.).
Walla Walla, Wash.-----	Lt. Col. Jesse J. Beatty (M. D.).
Washington, D. C.-----	Col. Lewis G. Beardsley (M. D.).
Waukesha, Wis.-----	Dr. Franklin C. Cassidy.
West Roxbury, Mass.-----	Gen. William J. Blake.
Whipple, Ariz.-----	Dr. Albert G. Walker.

*Summary*

Type of station	Number of stations	Managers	
		Medical	Lay
Area offices-----	9		0
Insular offices-----	3	1	2
Regional offices-----	20		20
Combined facilities-----	37	5	32
Facilities-----	60	53	7
Total-----	129	59	70

Mr. SCRIVNER. While you are on that, General, was not that desire on the part of your doctors, to have doctors as managers of the hospitals, due at least in part to the fact that that is one way in which your medical men may get into a higher salaried bracket?

General HINES. That may be their desire but they are not shut off from getting into the higher salaried brackets.

Mr. SCRIVNER. I understood from someone who testified here—I cannot recall who just now—that your managers, in most instances—

General HINES. The manager is the top classification.

Mr. SCRIVNER. Yes; were in the top classifications.

General HINES. That is correct.

Mr. SCRIVNER. And naturally, as a man progresses, if he has any ambition at all, he is looking toward the future, and he likes to get into that top classification. That would be his natural desire.

General HINES. Well what I meant to say, Congressman, was this: that they are not limited. They may, at a particular station, be limited in that way, but there are other grades just as high in the medical service.

Mr. SCRIVNER. But, largely, the success or failure of the manager of any of these facilities boils down to the personal element.

General HINES. That is absolutely right.

Mr. SCRIVNER. Regardless of whether it is a doctor or a layman, it all boils down to his ability to really manage the hospital?



General HINES. That is correct.

Mr. SCRIVNER. Whether he is a doctor, or otherwise?

General HINES. Yes, sir. I think the rule could very well be followed that in a straight hospital, if you are able to get a qualified medical man—and most certainly we should—the manager should be a doctor.

Mr. SCRIVNER. At the same time, while we are looking at the picture of the acute shortage of medical men, if there is a possibility of using more laymen as managers, you have just that many more medical men available to pursue their professional duties.

General HINES. That is correct, and we have had, many times, to go in that direction recently, so as not to waste medical personnel.

Mr. McQUEEN. General, may I ask a question along that line. Would you now recommend, under the present system, that the regional offices be divorced entirely from the hospital proper, with the load that you now have and anticipate?

General HINES. Yes; we are going in that direction very rapidly. Wherever it is feasible at this time, due to the increased load coming to the adjudication activities, the regional offices are being separated from the combined facilities.

The reason they were put together was the reason I stated this morning; the peak load of World War I was over, and the consolidation of a regional office with a hospital and a home saved about 10 percent of the administrative expense. And there is a great convenience to the veteran.

In other words, if he can go to one place, in a given community, wherever the facility is located conveniently to transportation, and at that point get all that the Government can do for him, he is better off than to go to one place for something and be sent to the hospital later.

I think you will find that, except for increased load, which will require us to separate regional offices and establish branch offices in addition to regional offices, that the combined facility is very satisfactory.

Mr. McQUEEN. Well, the medical situation and the managerial situation would sort of work themselves out if they were divorced; that is if the manager was in charge of the regional office, he would naturally assume, then, that a doctor would be in charge of the hospital, if it were a few miles from there?

General HINES. That is right.

Mr. McQUEEN. So that would work itself out under the present arrangement, would it not?

General HINES. It would. One of the difficulties with which we are faced now, of course, in separating regional offices from hospitals, is the lack of medical personnel. Because as soon as you establish a regional office, you have a certain medical crew that has to go with that regional office. Where you have a combined facility they can be used for both purposes.

So that we will have difficulty, until more medical officers become available, in going as fast as we would like to in separating regional offices from hospital facilities.

Now, during the course of the investigation something was said about not encouraging doctors to perfect themselves in their profession, take refresher courses, and so on. I would like to read a brief extract from a report of the Director of the Veterans' Bureau of June 30, 1927, and I know of no change in policy since that date. In fact, it was in existence prior to that date. This is under the subject of Research and it also takes up the subject of encouraging doctors to take advantage of the opportunities to attend courses in colleges and schools.

On page 9 of that report, rendered to the Congress, it states:

Two meetings of the Medical Counselor Bureau were held in the central offices in Washington, D. C., the first on November 8 and 9, 1926, and the second May 12 and 14, 1927.

Among the various subjects considered by the special groups of the council were: Maintenance of professional standards among the medical personnel of the Bureau; approval of a Medical Corps organization similar to that of the Army, Navy, and Public Health Service; creation of wards for psychopathic patients in general hospitals; measures to secure proper discipline of patients in the hospitals; advisory opinions on classifications, etc.

#### Then under research:

The medical research work of the Bureau is supervised by a small organization established in the medical service of the central office. The functions of this agency, broadly speaking, are the study of methods of examination, both clinical and laboratory, and of treatment in hospitals and dispensaries of the Bureau, for the purpose of measuring progress in results and developing and applying improved methods. Statistical and analytical studies made by the agency appear from time to time in the Medical Bulletin, the interesting and valuable monthly publication of the medical service.

Results of the studies are also published in separate pamphlets bearing upon such subjects as standardization of technique, tests, recent therapy, diagnoses criteria, nomenclature of diseases, etc.

Encouragement has been given, in this as in the preceding fiscal years, to the development of research work in general throughout the service. During this year, no less than 61 separate research problems were completed by hospitals, field stations, and central offices. Indicative of the diversified character of these studies are the following—

General HINES. Then they take up the different psychopathic diagnoses, red-cell blood tests, comparative studies of various kinds, findings, and so on.

More recently we have had postgraduate instruction for medical officers; since July 1, 1943, courses at Mayo, 3 months, five physicians; courses at the University of Illinois, 2 weeks, one physician; a course in electric-shock treatment, Oregon State Hospital, 2 weeks, one physician; course in eye, ear, and nose diseases, New York Eye, Ear and Nose Infirmary, one physician.

I have here, Mr. Chairman, four pages of different courses which doctors have taken in recent years, since 1943, and I might say, in connection with it, that encouragement to attend has been given, but we have had to limit the number of doctors that we could spare, due to the shortage of doctors.

But I cannot understand where the impression came from that we were not encouraging research and development of improvement in medical practice. One of the most outstanding tests is just being completed, to determine the type of X-ray equipment, covering the entire field of all the equipment used by the Army and Navy and the Veterans' Administration, and recently a preliminary report of a group of specialists which had been studying 4,000 cases has been presented by the chairman of that group to the National Research

Council, and he told me only a few days ago that he would be glad to appear before this committee to give you more details of that study. But its far-reaching effect, he says, cannot be measured. Already it has saved millions of dollars to civilian institutions, by them being able to tell the very fact that it is not essential that you have a 14- by 17-inch plate as against a 35 millimeter plate.

That test was started by the Veterans' Administration for one purpose: the purpose of making sure that, in the X-ray of these men coming out of the service, we would get records that would be useful in future years in the adjudication of their claims.

We knew that the Army and Navy were using various types; we knew that some of the manufacturers were proposing that other types were better; we undertook that study. There has not been one of such magnitude conducted, and I am satisfied that the results will be far-reaching.

Dr. Cutler explained to you somewhat the development of cancer research work. We are not following anyone in that work. We are leading.

There are many other tests, such as on allergies of various kinds, that have been going on for some time in our institutions. They have been slowed up, necessarily, because of shortage of personnel and increased load in taking care of other things.

With your permission, Mr. Chairman, I would like to insert this list of postgraduate courses for medical officers in the record.

The CHAIRMAN. Without objection, it is so ordered.

(The list referred to is as follows:)

#### POSTGRADUATE INSTRUCTION FOR MEDICAL OFFICERS SINCE JULY 1, 1943

- Course in anesthesiology, Mayo Clinic, 3 months, five physicians.
- Course in bronchoscopy, University of Illinois, 2 weeks, one physician.
- Course in electric shock, Oregon State Hospital, 2 weeks, one physician.
- Course in eye and ear diseases, New York Eye and Ear Infirmary, New York City, N. Y.; 1 month, one physician.
- Course in maxillo facial surgery, Mayo Clinic, 3 months, two physicians, two dentists.
- Course in military neuropsychiatric, Mason General Hospital, Brentwood, Long Island, N. Y.; 6 weeks, 17 medical officers.
- Course in neurology, clinical neurology, Mayo Clinic, 3 months, one physician.
- Graduate course in otology, rhinology, and laryngology, University of Cincinnati, 1 week, one physician.
- Course in oral surgery, Hines Facility, 1 month, six dentists.
- Course in pathology, Hines Facility, 3 months, one physician.
- Course in physical medicine and rehabilitation, Mayo Clinic, Rochester, Minn., 12 weeks, 10 medical officers (including 1 week at University of Minnesota for instruction in the Kenney treatment, and 1 week at Northwestern University for special instruction in physical medicine).
- Course in diagnostic radiology and pathology, Hines Facility, 3 months, one physician.
- Course in general surgery, Los Angeles Facility, 1 month, one physician.
- Course in prefrontal lobotomy, George Washington University, 15 days, four physicians.
- Course in psychoneurosis, La Garde General Hospital, 3 weeks, one medical officer.
- Course in roentgenology, Hines Facility, 6 weeks, one medical officer.
- Course in electric shock therapy and electroencephalography, Northport Facility, 2 weeks, three medical officers.
- Course in electroencephalography, Northport Facility, 2 weeks, one medical officer.
- Course in electric shock therapy, North Little Rock Facility, 2 weeks, one medical officer.



Courses in physical medicine, 12 weeks:

Mayo Clinic, Rochester, Minn.; six medical officers.

Northwestern University, Chicago, five medical officers.

Cornell University, New York City, four medical officers.

Course in roentgenology and pathology, Hines Facility, 18 weeks, one medical officer.

Course in subshock insulin treatment, Vaughan General Hospital, Hines, 10 days, one medical officer.

Course in tropical diseases, Walter Reed Hospital, 8 weeks, 10 medical officers.

Special training at Army amputation centers, 6 weeks:

Bushnell General Hospital, Brigham City, Utah; two medical officers.

Lawson General Hospital, Atlanta, Ga.; two medical officers.

McCloskey General Hospital, Temple Tex.; two medical officers.

Percy Jones General Hospital, Battle Creek, Mich.; two medical officers.

Walter Reed General Hospital, Washington, D. C.; one medical officer.

England General Hospital, Atlantic City, N. J.; two medical officers.

Course in rehabilitation of more severely disabled veterans; Institute for Crippled and Disabled, New York City; 3 weeks, 36 physicians, 18 physical-therapy technicians, 17 psychiatric social workers, 15 occupational-therapy technicians.

APPROVED COURSES FOR TRAINING IN THE NEAR FUTURE

Course in rehabilitation of deafened; Hoff General Hospital, Santa Barbara, Calif.; 5 days; one medical officer.

Course in anesthesiology, Mayo Clinic, 12 weeks, one medical officer.

Course in endoscopy, Temple University, Philadelphia, Pa.; 2 weeks, one medical officer.

Course in gastroscopy, Columbia University, New York City; 2 months; one medical officer.

Course in group therapy of psychoneurotics, Brooke General Hospital, Fort Sam Houston, Tex.; 10 days, one medical officer.

Course in physics and technology; Massachusetts Institute of Technology, Cambridge, Mass.; 10 weeks, one medical officer.

Clinical course in tuberculosis; Saranac Lake, N. Y.; 6 weeks, three medical officers.

Courses in the rehabilitation of the more severely disabled veterans will be continued at the Institute for the Crippled and Disabled until sufficient medical personnel have been trained to cover this phase of therapy.

General HINES. Now I think the other day, when someone was testifying the question came up with reference to the Medical Corps, and why it had not been proposed before, and so on. Without taking up too much of the time of the committee, I would like to give you a brief history of previous actions in relation to that, and the record is here if you desire to get more detail.

The records show that following the enactment of the Consolidation Act of August 9, 1921, the problem arose with reference to the administration of pay and allowances of officers of the Public Health Service who came under the jurisdiction of the Veterans' Bureau. In this connection reference is made to the opinion of the Comptroller General, June 3, 1922, A. D. 6792 (unpublished manuscript opinion).

June 10, 1922, a draft of proposed legislation to create in the United States Veterans' Bureau a medical service consisting of a Medical Corps, Medical Reserve Corps, Dental Corps, Dental Reserve Corps, Nurse Corps, and other necessary personnel was drafted in the office of the general counsel, subsequently revised and forwarded to Dr. Scott, the Executive Office, November 20, 1922. With some changes, the draft was forwarded to Gen. E. A. Kreger, State, War, and Navy Building, November 24, 1922, by Dr. Robert Q. Patterson, Assistant Director. Numerous redrafts followed.

Under date of February 15, 1923, there was forwarded to Hon. Burton E. Sweet, House of Representatives, a discussion of the

needs of a United States Veterans' Bureau Medical and Dental Corps, together with estimate of cost.

Mrs. ROGERS. General Hines, he was the chairman of the Interstate and Foreign Commerce Committee?

General HINES. Yes; they handled the legislation at that time.

The letter was over the signature of L. B. Rogers, Assistant Director. No official action was taken during that session which terminated March 4, 1923.

Under date of November 4, 1923, the Director, Brig. Gen. Frank T. Hines, dispatched a memorandum to Maj. William Wolff Smith, general counsel, referring to the study which had been given to creating a Medical Corps for the Veterans' Bureau and such memorandum reads in part:

Investigation leads me to believe that there is real need for correcting certain discrepancies which are apparent and that a possible means of solution would be through the creation of a Medical Corps, adequate to meet all the requirements of the Veterans' Bureau.

He requested that a draft of proposed legislation be prepared and coordinated with the Medical Service.

On November 24, 1924, the Director, General Hines, transmitted to the general counsel the minutes of the Medical Council and the draft of a bill recommended by them, requesting preparation for submission to the President. The copy of the minutes of the Medical Council, November 10 and 11, 1924, is marked in the legislative file, 2-4, part II.

A copy of a memorandum in file dated November 29, 1924, from the Special Legislative Committee to the Director, over the signature of the general counsel, Assistant Director, Supply Director, and Medical Director, transmitting a draft which followed in general the draft recommended by the Medical Council with the following differences.

The Medical Council's draft divided the Medical Service into three corps, namely, the Medical, Dental, and Nursing, whereas the redraft recognized no corps and eliminated all provisions for the nursing personnel. Also the provisions for a reserve corps in the Medical Council's draft were omitted in the redraft.

The next record shows that under date of December 4, 1924, the general counsel submitted a draft dated December 4, 1924, and the first bill on the subject introduced in the Congress was introduced by Congressman Snyder, December 9, 1924, H. R. 10534, Sixty-eighth Congress, second session. This bill was identical with the draft of December 4, 1924, and included a Nurse Corps and is more comparable with the draft of the Medical Council.

There next appears in the file a copy of a letter of December 17, 1924, addressed to the United States Civil Service Commission concerning resolutions of the rehabilitation committee, American Legion, passed at their National convention in St. Paul in September 1924, to the effect that—

Civil Service has proven to be an absolute failure for the selection and procurement of competent and humane medical personnel \* \* \* and that classification under Civil Service is not conducive to the maintenance of efficiency in professional corps.

And the final resolution, to the effect that—

The American Legion favors, and the American Legion will fight for the creation by Congress of a Veterans' Bureau Medical Corps similar to that of the Public Health Service, the Army and the Navy.

The letter referred to H. R. 10534 and the reasons for the Veterans' Bureau favorable attitude toward the bill, without reflection on the Civil Service.

Under date of January 5, 1925, a report was furnished the Committee on World War Veterans' Legislation on H. R. 10534, recommending the enactment into law and making recommendation for one amendment. So it is shown I recommended a corps to the Congress as early as 1925.

Under date of January 28, 1925, a subcommittee of the Committee on World War Veterans' Legislation conducted hearings on H. R. 10534, and my statements appear throughout the hearings.

Mrs. ROGERS. Was not that incorporated in an omnibus bill that was introduced by Royal Johnson at that time?

General HINES. No, it was not. They held hearings, but I think I have a statement a little further on about it. For some reason the committee did not recommend the legislation.

However, in the Sixty-ninth Congress, first session, Mr. Connery introduced H. R. 5975. The report to the chairman of the Committee on the bill, March 8, 1926, referred to the prior report on similar provisions and the hearing on H. R. 4474 of the Sixty-ninth Congress at which time the provisions of H. R. 10534 were discussed by me.

The records show a bill to amend the World War Veterans' Act, 1924, H. R. 10240 Sixty-ninth Congress, first session, introduced by Hon. Royal Johnson, South Dakota, March 11, 1926, and reported by the committee without amendment on the same date. This bill contained similar provision with reference to the Medical Service, composed of a Medical Corps, Medical Reserve Corps, Dental Corps, Dental Reserve Corps, and a Nurse Corps. This bill however was not enacted into law and H. R. 12175 which became the act of July 2, 1926, Public Law 448, Sixty-ninth Congress, did not contain the Medical Corps.

That is the bill you referred to, Mrs. Rogers.

Mrs. ROGERS. Yes.

General HINES. I can go on, as there is quite a long history. Finally, I think Congressman Rankin, and also Mrs. Rogers, later, introduced similar bills.

Mr. SCRIVNER. How much later?

General HINES. Well, I can give you the exact date.

Mrs. ROGERS. We tried to have it go through as a separate measure.

General HINES. Well we have H. R. 5833, drafted for the D. A. V., which was introduced by Mr. Rankin by request December 5, 1931, Seventy-second Congress, first session, and an identical bill, S. 1697, introduced by Senator Reed by request.

The report from the Veterans' Administration to the Committee on Finance on S. 1697, March 2, 1932, referred to the consideration of Congress at that time to all classes of employees and stated that the proposed legislation should be given further study to better determine the better treatment to be given all groups.

That followed somewhat the suggestion which Colonel Ijams made to the committee, that we should keep in mind always that the medical



set-up of the Veterans' Bureau is only a small part of the total set-up. We have a large insurance company, and a large adjudication system, with a very large supply system.

Mrs. ROGERS. General Hines, if you had had the Medical Corps, it seems to me the other would follow naturally.

General HINES. Well it would in this bill, because it would all go in the armed services in time of need.

Mrs. ROGERS. The medical bill is of prime importance because it means the saving of human life.

General HINES. Then a bill was introduced by Mrs. Rogers for the establishment of a medical corps. The Veterans' Administration reported on that and indicated that the study which had been given to the matter, the recruitment program which had been established, and referred to the hearings on this proposal before the Committee on World War Veterans' Legislation, February 6 to 16, 1940, pages 98 to 101. It was indicated that effort was being made in coordination with the Civil Service Commission and the service departments to establish a more satisfactory system of recruitment for Veterans' Administration facilities.

Although the report was unfavorable it stated that it was the intention of the Administrator to report to the committee at future hearings or informally at the appropriate time the progress of the new approach to the problem.

I might say that during the whole course, except in the early stages, there has not been an approval of the Bureau of the Budget to such an institution. We have always been faced with the thought that, in time of peace, the organization should be on a civilian basis; that the effort should be made to improve the standards of doctors in civil service.

If that were possible, you might find that the veterans themselves would prefer such a system. In the design of the bill now before you, it is hoped that it can be maintained, in time of peace, on a civilian basis, but not necessarily under civil service, where the standards for the doctors, and standards for nurses and attendants can be raised, and so that all the personnel would be selected by those who know the type of personnel to be had.

Now I doubt if there is need to discuss the Medical Corps any further, unless there are some questions which the members of the committee would like to ask.

Mrs. ROGERS. General, why did you recommend a change in section 30 of the bill?

General HINES. Well, I did that purposely, for the reason that I feel that the Veterans' Administration, in its increased capacity, which will carry its personnel, I should say, close to 100,000, that there is no good reason why the classification of the top assistant administrator and the medical directors, should not be in the highest grade given under the Classification Act. That can only be done by legislation. That was the purpose of that section.

Mrs. ROGERS. Well that would be under you, rather than under the Medical Corps?

General HINES. Yes, it would be under the Administrator.

Mrs. ROGERS. It seems to me it did not belong in the Medical Corps bill. It ought to be in a separate bill.

General HINES. Well I have no objection. It is a kind of rider. I rather expected that that question might be raised, but it seems to me you could cure both things at the same time.

Mrs. ROGERS. But it seems to me that it puts the Medical Corps in exactly the same position in which it is now.

General HINES. No. As a matter of fact, the Surgeon General of the Medical Corps, under this bill, would receive the same pay as the Surgeon General of the Army or Navy.

Mrs. ROGERS. Yes, but I think, as far as the legal counsel, and your assistants are concerned, they would still have the same power over the Medical Corps that they have today.

General HINES. Well I feel that with respect to some of these smaller departments, which have assistant secretaries, which correspond very much to the assistant administrators, and being a grade higher than those in the Veterans' Administration, that it is hardly fair to those.

Mrs. ROGERS. Well can it not be in a separate bill?

General HINES. I would have no objection to it coming out of there. I think you would probably have less objection to it going through on this bill, but I would certainly have no objection to it.

Mrs. ROGERS. It is not a Medical Corps bill with that in it, it would seem to me.

Mr. SCRIVNER. General, this morning I asked a question about whether or not you had asked this committee to help you on these matters, and the comment was made that, after all, you were under the executive branch, and that this was legislative; I did not care to carry it any further then, but I do want to observe that, after all, the Executive is there to carry out the laws enacted by the Congress.

General HINES. That is right.

Mr. SCRIVNER. But I did understand you to say that you did not propose—I may be wrong about this now—that you personally did not propose any Medical Corps prior to 1933.

General HINES. Well, I proposed it originally, away back in the early days in 1925, and that was turned down.

Mr. SCRIVNER. Well, apparently it began along about in 1922, and then on up to 1924; I have forgotten when you came with the Administration.

General HINES. March 2, 1923.

Mr. SCRIVNER. Yes, I think there was a draft of the general counsel in December of 1923. Then it seems to have died a natural death, or maybe it just went into hibernation, from 1926 to 1931, and then there was not much activity on behalf of it until 1942 or 1943. Yet, if I recall the statement of Colonel Griffith and Colonel Ijams, both, my recollection is that they both had been in favor of a separate corps like this since 1924, or thereabouts.

General HINES. Well, I do not know, but I know that it came up from time to time in the Medical Council, it came up in Legion meetings. But up to the time that we got into this war, we were staffing our hospitals very satisfactorily with doctors; some of them were not of as high grade as I think we should endeavor to get, but we were getting good material.

Mr. SCRIVNER. Well, while you are on that point, how did the staff, and the manner in which you staffed your hospitals, together with the rate of pay, compare with the Public Health Service?

General HINES. I think it was about the same.

Mr. SCRIVNER. The reason I ask that is that there is an inference, at least, here, that the Public Health Service had not apparently been running into quite as much trouble as the Veterans' Administration had.

General HINES. Well the Public Health Service had a corps, and of course they have retirement features.

Mr. SCRIVNER. And these doctors have it under civil service, have they not?

General HINES. The retirement is not as great as—50 percent and 75 percent, I think.

Mr. SCRIVNER. In other words, Public Health Service doctors obtain a higher retirement benefit than those of the Veterans' Administration?

General HINES. Yes, and it seems to me—though I would want to check the grades—that our doctors, in comparable jobs, were very close to the Public Health standards at that time.

Mr. SCRIVNER. So the only benefit these men in Public Health would have would be a higher retirement benefit?

General HINES. Yes. And Public Health, as you noticed recently, has been taken into the military service.

Mr. SCRIVNER. I noticed that.

General HINES. Another thing, there is a vast difference between the deductions. I do not believe the Public Health Service makes any deductions for their retirement feature, while under civil service you do have deductions. I would have to verify that, but I think it is right.

Mr. SCRIVNER. In other words, as I understand it, General Bradley is going to look into this matter rather thoroughly upon his return and make an estimate of the situation?

General HINES. That is right.

Mr. SCRIVNER. It might be well, then, in view of the suggestion made of comparison with the Public Health Service, that we possibly might want to study their set-up while we are figuring on a new one for the Veterans' Administration.

General HINES. I think Mr. Odom made some study of it in drafting this bill, did you not, Mr. Odom?

Mr. ODOM. Yes.

Mr. SCRIVNER. Has that been submitted to the committee?

Mr. ODOM. The study has not, but it will be in due course of time.

Mr. SCRIVNER. I think we should have that.

Mrs. ROGERS. I think it was in 1925 when there was so much discussion regarding the Medical Corps bill, General Hines, and the bill was finally introduced by Royal Johnson, and then I know you and I discussed seeing what could be saved from the wreckage at that time.

General HINES. Yes. The fact remains that the doctors that were in the Veterans' Administration service at that time were not all in favor of a corps bill. There was a great difference of opinion on it, and I think that probably some of that was brought about by the desire of not having our doctors in uniform.

Mr. SCRIVNER. I think that is probably right, too, General, and I think that you will probably find that same reaction facing us now. I can recall the early days when I went into a hospital. My recollection is that at that time, in 1920 or 1921, some of these doctors



were Public Health doctors, and of course they were in uniform, and having put in a few months, most of us were most anxious to get as far away from uniform and rank as possible, and I think you are probably going to run into the same thing after this is all over, and in thinking about this, although there will be some sort of a Medical Corps set up, I think the farther away you can get from titles, such as "major" or "colonel" or "captain," and the farther away you can get from anything that even smacks of a uniform, the better satisfied your civilian patients are going to be.

General HINES. I thoroughly agree with you, and I am sure that the bill is designed to do that. Maybe some of the titles will have to be changed. We use "director." But there is no excuse for any uniform in time of peace, except a hospital uniform.

Mr. SCRIVNER. And I do not know whether they need that, outside of their regular medical garb—white gowns, and so forth. I know I have talked to some of these men who have recently come out, and they much prefer, and feel much better, when they are calling these men "doctor" rather than "colonel" or "major." And they feel freer with them. Even though they are discharged now, and do not have to worry so much about military discipline, they still recoil and freeze up just a little in the presence of rank.

General HINES. That is right.

Mr. SCRIVNER. Of course, it may be that some day they will get over that.

General HINES. Well, they will not for the immediate future, and of course I do believe that you will be forced into the proposition of a uniformed corps in time of war.

Mr. SCRIVNER. Of course, the San Francisco Charter is supposed to obviate the necessity for that.

The CHAIRMAN. Do you not think that the uniform also has an effect upon the doctor, making him feel more as an Army officer than a doctor?

General HINES. Yes.

Mr. SCRIVNER. Before we get too far, General, as we are thinking about setting up a medical corps here, we are thinking primarily of the future. What proposal do you have, if any, for an immediate remedy? In other words, I am thinking of this: if we go to a tailor, and he has a piece of cloth which we would like to have made into a suit; it may be limited in size, and he might say: "Well now, that piece of cloth only contains so many yards and all I can do is just make you a coat and a pair of trousers. But here is another piece that is a little larger; with this piece of material I can make you a coat and a vest and a pair of trousers; and here is another piece of cloth, an unlimited supply, out of which, if you desire, you can have a coat, a vest, and two pairs of trousers." In other words, we must cut the suit to the cloth at our disposal. We only have so many doctors, so many nurses, and so many attendants.

General HINES. We will have to limit our hospitalization to the nurses and doctors in attendance.

Mr. SCRIVNER. I was just hoping that before you got through you would bring that out, because the figures showed that 80 percent of our load was now non-service-connected.

General HINES. That is correct.

Mr. SCRIVNER. And I think the figures you gave earlier this morning, of the general medical and surgical for World War II men, showed that out of 104,000 there are only 18,000 service-connected. In other words, almost 80 percent of our patient load in World War II in general medical and surgical, is for non-service-connected.

General HINES. You will find a large percentage of the World War I men in the same class.

Mr. SCRIVNER. Yes, I think the figure there is the same.

General HINES. There is just one other way out, and I am not sure that it is feasible, because the War Department has served notice on us that no doctors coming out of the service, or who are to be released from the service, will be assigned to our service without their consent. That means that we will get very few doctors.

Mr. SCRIVNER. There will not be very many of them. They will want to get home.

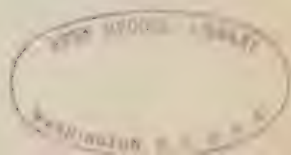
General HINES. Yes, most of them want to go home, and want to reestablish their practice. So I am quite sure that unless there is a material change in the war situation and the rate of discharge of medical personnel—and I cannot see where the hospitals of the Army and Navy can reduce very much within the next 2 years, no matter what happens.

Mr. SCRIVNER. In connection with that, we have been told that there are a large number of vacant beds, comparatively speaking. As you get that picture of so many vacant beds, the public gets the impression of a lot of vacant spaces there.

General HINES. That is right.

Mr. SCRIVNER. Do you have those figures compiled as to certain hospitals, to show that while we have certain hospitals with vacant beds, we must keep them vacant because we do not have doctors, nurses, or attendants to take care of them? I think if that picture were given, in just exactly that way, it might make some people understand just a little better the situation we are facing.

General HINES. Well I have a report here, which may not be as near up to date as we would like, but which can be brought up to date. It gives the occupancy of the Army, Navy, and Veterans' Administration hospitals. I do not have it right now, but I will place it in the record, if you so desire; that is, the number of beds available in the Army, Navy, and Veterans' Administration hospitals, together with the utilization of such beds.



(The statement follows:)

## VETERANS' ADMINISTRATION

*Beds occupied by Veterans' Administration beneficiaries in other Government hospitals as of June 28, 1945*

	World War II				Other wars and regular establishment				Total
	Service-connected	Non-service connected	Observation	Total	Service-connected	Non-service connected	Observation	Total	
Federal Security Agency:									
United States Marine Corps:									
Baltimore, Md.		3		3		3		3	3
Buffalo, N. Y.						1		1	4
Carville, La.	3	8		11	5	9	14		25
Cleveland, Ohio	9	33		42	2	63		65	107
Detroit, Mich.	1	41		42		84		84	126
Evansville, Ind.		4		4		9		9	13
Galveston, Tex.	1	21		22	2	35		37	59
Louisville, Ky.	2	20		22	2	67		69	91
Mobile, Ala.		8		8		5		5	13
New Orleans, La.	1	24		25	6	52		58	83
Norfolk, Va.						5		5	5
San Francisco, Calif.		3		3		6		6	9
San Juan, P. R.		6		6		22		22	28
Savannah, Ga.		14		14		21		21	35
Seattle, Wash.	3	35		38	1	88		89	127
Stapleton, N. Y.	6	4		10		8		8	18
Total United States Marine (16)	26	224		250	18	478		496	746
St. Elizabeths, Washington, D. C.					50	25		75	75
United States Army:									
Army and Navy General, Hot Springs, Ark.	13	22		35	8	63		71	106
Baxter General, Spokane, Wash.	1	19		20	1	37		38	58
Brooke General, San Antonio, Tex.	13	26		39	2	37		39	78
DeWitt General, Auburn, Calif.		6		6		2		2	8
Fitzsimons General, Denver, Colo.	16	35		51	38	74		112	163
Foster General, Jackson, Miss.	1			1					1
Hammond General, Modesto, Calif.	2	5		7		13		13	20
McCaw General, Walla Walla, Wash.	1	17		18	4	10		14	32
Oakland Regional, Oakland, Calif.	1	14		15		28		28	43
Pasadena Regional, Pasadena, Calif.	3	34		37	1	55		56	93
Walter Reed General, Washington, D. C.	3	1		4	1	1		2	6
William Beaumont General, El Paso, Tex.	5	9		14	2	7		9	23
Territory of Hawaii		11	3	14	1	15	1	17	31
Total Army (13)	59	199	3	261	58	342	1	401	662
United States Navy:									
Bethesda, Md.		6		6		8		8	14
Charleston, S. C.		2		2		6		6	8
Chelsea, Mass.						1		1	1
Corpus Christi, Tex.	4	28		32	4	44		48	80
Dublin, Ga.		7		7		13		13	20
Long Beach, Calif.	3	34		37		66		66	103
Mare Island, Calif.	1	8		9		22		22	31
Memphis, Tenn.	5	5		10		1		1	11
New Orleans, La.	10	19		29	2	11		13	42
Newport, R. I.	8	14		22	2	35		37	59
Pensacola, Fla.	3			3	1			1	4
Philadelphia, Pa.	18	93	3	114	28	320	1	349	463
Portsmouth, N. H.	2	1		3		7		9	12
Portsmouth, Va.—Norfolk Naval Base		2		2		2		2	4
Puget Sound, Wash.		8		8		13		13	21
St. Albans, N. Y.	2	34	3	39	1	60	1	62	101
San Diego, Calif.	5	43		48	2	84		86	134
Seattle, Wash.	5	32		37	3	56		59	96
Shoemaker, Calif.	2	26		28	2	64		66	94
Territory of Hawaii		1		1		2		2	3
Total Navy (20)	68	363	6	437	47	815	2	864	1,301
Grand total (50)	153	786	9	948	173	1,660	3	1,836	2,784



*Beneficiaries receiving hospital treatment and domiciliary care as of June 28, 1945*

[illegible]

*Beneficiaries receiving hospital treatment and domiciliary care as of June 28, 1945—Continued*

Veterans' Administration facilities	Authorized beds		Beneficiaries receiving hospital treatment										Beneficiaries receiving domiciliary care										Grand total all beneficiaries in Veterans' Administration facilities	Included in beneficiaries receiving domiciliary care		Beds occupied over authorized capacity included in grand total beneficiaries	
			World War II				Other wars and Regular Establishments				Non-Veterans' Administration	Total receiving hospital treatment	World War II			Other wars and Regular Establishments			Total beneficiaries receiving domiciliary care								
	Hospital	Domiciliary	Service-connected	Non-service-connected	Observation and temporary hospitalization	Total	Service-connected	Non-service-connected	Observation and temporary hospitalization	Total			Service-connected	Non-service-connected	Total	Service-connected	Non-service-connected	Total									
NEUROPSYCHIATRIC—CON.																											
Knoxville, Iowa.....	1,964		195	63		258	494	839		1,333	1	1,592								1,592							
Lexington, Ky.....	832		173	46	7	226	118	357	1	476	1	703					1	1	1	704							
Lyons, N. J.....	2,043		329	147		476	555	918		1,473		1,949								1,949							
Marion, Ind.....	2,340		234	59	1	294	500	887		1,387	76	1,757								1,757							
Mendota, Wis.....	269		61	10		71	60	35		95		166								166							
Murfreesboro, Tenn.....	1,007		198	172		374	157	361	1	519		893								893							
Northampton, Mass.....	1,006		197	34		231	333	423		756	1	988								988							
North Little Rock, Ark.....	1,625		342	92	1	435	391	737		1,128		1,563					1	1	1	1,564							
Northport, Long Island, N. Y.....	2,806		454	259		713	1,139	882		2,021	8	2,742							3	2,745							
Palo Alto, Calif.....	1,417		179	80		259	433	612		1,075	16	1,350								1,350							
Perry Point, Md.....	1,852		160	223		383	432	844		1,276		1,659								1,659							
Roanoke, Va.....	1,697		262	261	3	526	180	87	1	1,038	8	1,572								1,572							
Roseburg, Oreg.....	659		79	33		112	118	339		457		569								569							
St. Cloud, Minn.....	1,570		233	40	1	274	398	532		930	1	1,205								1,205							
Sheridan, Wyo.....	713		66	22		88	200	396		596		684								684							
Togus, Maine.....	1,102		242	164	1	407	87	149		236	5	648								648							
Tuscaloosa, Ala.....	791		97	135	5	237	63	246	1	310		547								547							
Tuskegee, Ala.....	1,931		241	283	16	540	177	989	3	1,169		1,709								1,709							
Waco, Tex.....	1,886		309	198	8	515	239	798	3	1,040		1,555								1,555							
Wadsworth, Kans.....	2,064		72	62	2	136	52	394		446	1	583					1	4	5	588							
Total neuropsychiatric (32).....	47,814		6,650	3,504	56	10,210	10,350	20,439		10,307	125	41,134					1	13	14	14	41,148			7	11		
GENERAL MEDICAL AND SURGICAL																											
Albuquerque, N. Mex.....	313		51	31	4	86	22	108		130	2	218								218							
Alexandria, La.....	739		137	97	10	244	36	214		253		497								497							
Amarillo, Tex.....	180		9	27		36	4	101		105		141								141							
Aspinwall, Pa.....	1,134		74	282	3	359	20	370	2	392		754					1	1	1	755							
Atlanta, Ga.....	415		42	87	3	132	12	209		221		353					1	1	1	354							
Batavia, N. Y.....	204		26	37		63	5	152		157		220								220							
Bath, N. Y.....	428	1,476	11	31	1	43	16	232		248	2	293	8	27	35	96	978	1,074	1,109	1,402	1						
Bay Pines, Fla.....	604	824	27	84		111	34	349	1	384	1	496	6	33	39	37	559	596	635	1,131							
Biloxi, Miss.....	208	793	6	16	3	25	8	111	10	129	1	155	9	6	15	24	437	461	476	631							
Boise, Idaho.....	203	147	5	9		14	4	83		87	1	102			6	0	8	111	119	227							
Brecksville, Ohio.....	413		32	869	1	102	6	189		195	3	300								300							
Bronx, N. Y.....	2,084		289	356	8	653	28	1,010		1,038	2	1,693								1,693							
Cheyenne, Wyo.....	201		5	36	1	42	5	94	2	101	1	144								144							
Columbia, S. C.....	722		101	129	2	232	13	238	7	258	1	491								491							
Dallas, Tex.....	349		22	65	1	88	9	177		186	1	275					1	1	1	276							
Dayton, Ohio.....	1,044	2,574	107	110	7	224	34	620	2	656	2	882	1	21	22	47	1,495	1,542	1,564	2,446							
Dearborn, Mich.....	460		14	141		159	19	241	1	261		420								421							
Des Moines, Iowa.....	545		38	57	2	97	16	213		229		326								326							
Dwight, Ill.....	196		6	20		26	8	68		76	2	104								104							
Fargo, N. Dak.....	159		16	37		53	4	91		95	2	150								150							
Fayetteville, Ark.....	305		15	26	1	42	7	164	1	172		214					1	1	1	215							
Fayetteville, N. C.....	297		32	54	2	88	13	116	1	130	1	219								219							
Fort Harrison, Mont.....	384		8	23	5	36	10	72		81	2	119								119							
Fort Howard, Md.....	364		30	56		86	9	213	2	224		310								310							
Fort Washington, Md.....		151												3	3	7	33	40	43	43							
Hines, Ill.....	1,993		174	295	30	499	37	1,294	10	1,341	3	1,843								1,843							
Hot Springs, S. Dak.....	272	558	28	6		34	11	137		148		182	1	6	7	10	227	337	244	426							
Huntington, W. Va.....	266		32	52	10	94	4	128	3	135	10	239								239							
Indianapolis, Ind.....	345		24	46	2	72	8	167	2	177	3	252								252							
Jefferson Barracks, Mo.....	605		23	82	9	114	17	350	3	370	2	486								487							
Kecoughtan, Va.....	532	1,642	18	75	2	95	6	257	1	264	1	360	7	10	17	36	606	642	659	1,019							
Lake City, Fla.....	419		1	87	1	89	2	173	12	187		276								276							
Lincoln, Nebr.....	379		20	30	10	60	11	146		157		217								217							
Los Angeles, Calif.....	2,516	2,522	138	487	2	627	172	1,382	2	1,556	5	2,188	9	11	2121	141	1,978	2,119	2,240	4,428							
Marion, Ill.....	214		8	38	3	49	1	129		130	5	184								184							
Memphis, Tenn.....	560		45	107	43	195	17	239	9	265	1	461								461							
Minneapolis, Minn.....	808		103	91	2	196	30	454	5	489	3	688					3	3	3	691							
Montgomery, Ala.....	329		25	85	3	113	7	145	2	154	1	268								268							
Mountain Home, Tenn.....	553	1,781	41	90	4	135	18	247		265	3																



Mr. SCRIVNER. The reason I suggest that is because there is one hospital in California, if I am not mistaken, where someone stated one ward had been completely closed because they did not have sufficient staff.

General HINES. That frequently happens, and that has brought about the charge of crowded conditions, where they have had a limited supply of nurses, and they have had to draw the beds into—

Mr. SCRIVNER (interposing). Of course, I think everybody will agree, General, that our primary concern is with the service-connected disabled case.

General HINES. That is right.

Mr. SCRIVNER. That is our first charge. The rest of it just came about largely, as I recall it, along in 1924 and 1925, when we did have some vacant beds, we had the staff, and there was not any reason, if those beds and that staff were there, why non-service-connected cases should not be cared for.

General HINES. I made the recommendation to President Coolidge that he include it in his message to Congress that year, opening up these beds for the non-service-connected. And it was just as you have stated it. We had vacant beds, and we had the staff.

Mr. SCRIVNER. But even with what you call your emergency beds, where you have crowded them in a little more than you would like to have them crowded, it has put an overburden on your staff as it now exists, so it may be necessary to take out even some of those emergency beds and bring it down to a load that the staff can carry and properly care for.

General HINES. We did not expand our hospitals to the full limit of the emergency beds. We thought we did. But I think we have gone far enough with the personnel. We have reached the point now where beds and wards are only opened when nurses and doctors are available.

Mr. SCRIVNER. I think that is the way it should be.

General HINES. Mrs. Rogers, I have delayed answering your request, made early this morning, on the question of beds for women. We have available, for psychotic women patients, a total of 442 beds at seven facilities.

Mrs. ROGERS. Where are they, General Hines?

General HINES. Well, I can name some of them. Colonel Tripp, can you name some of them? Perryville is one.

Colonel TRIPP. We have made some beds available in one of the men's buildings.

Mrs. ROGERS. Well that results in even more overcrowding.

General HINES. And there are under contract 654 beds, additional beds, in 11 facilities, which would practically cover the country, but it will not provide for the final number of beds for women. We have an unusual load, about 300,000 women have been taken into the service—Waves, Waes, Spars, Auxiliary Corps of the Marine Corps. They are all eligible for hospitalization for service-connected or non-service-connected cases, and it might be well for the committee to give consideration to the complexity of that problem, which brings us into a little different form of hospitalization than we have had before, where we will have to have a staff of doctors that are competent to take care of women and the diseases that go with them.

Mr. SCRIVNER. That will bring about a situation, though, which will correct a situation that has been brought about, of lack of intern



ship in veterans' hospitals, because they did not include women patients. With that is it your view, then, that with the expected added women patients, it will make some of these hospitals acceptable as places where men may serve their internships?

General HINES. Yes; and undoubtedly we will have to staff them, so that they will help.

The medical council has on its agenda something to do with several important items; segregation of patients of World Wars I and II; the matter of developing our training centers to the point where we can have internship. That will necessarily mean that we should, if we can, go the full extent with that sort of training, establish some of our training centers nearer some of the other training centers.

Mrs. ROGERS. General Hines, you approve of the large veterans' center in Washington, do you not, with training for doctors and nurses? And other personnel also?

General HINES. Yes; I recommended that, and the Board yesterday recommended it to the President. I am not sure, but it is included in the program that I referred to.

Mr. SCRIVNER. Why would not that make a much more acceptable and practical war memorial than a stadium, which is only used at certain times?

General HINES. It would. You could not make a better memorial.

Mr. SCRIVNER. I think that is right.

Mrs. ROGERS. General Hines, I have been much troubled because a lot more is not being done for the spinal-cord cases, of which you have such a large number.

General HINES. Well, Mrs. Rogers, I think we have done about as much as can be done. Wherever it is possible to get a surgeon who is competent to handle those cases, we have tried to establish, and have established, at the nearest point, a facility where those men can be cared for. You are familiar with what is being done at West Roxbury under Doctor Monroe.

Mrs. ROGERS. Yes; but he can only take the Boston City Hospital, and because of the crowding there, he has only had three patients in all, and only operates there because there is no doctor at West Roxbury who can handle those operations. And the Bronx is not very far advanced. The Army will not let you have doctors of that type.

General HINES. We have some of our own doctors, and those on the consulting staff are about as good. As a matter of fact, I am sure that we are very well advanced in that problem, and the Army has turned those cases over to us, as you know, quite promptly, and in quite large numbers.

Mrs. ROGERS. Yes but you have not the adequate staff, General Hines. I have gone into that a little bit.

General HINES. We have not a full time staff, but we have a good consultant staff.

Mrs. ROGERS. The boys are extremely unhappy there, because more cannot be done.

General HINES. Well, unfortunately I did not get a chance to talk to Dr. Monroe, but I am sure Dr. Griffith did.

Mrs. ROGERS. The Army has taken Dr. Landry. Dr. Landry was to be trained for West Roxbury and the Army has taken him. So there is no specialist at West Roxbury. There is a very nice doctor there, but he has not had much training in it. I think the Bronx

is beginning to do good work. General Hines, what are you going to do with these non-service-connected cases in the hospitals?

General HINES. Well, we cannot do anything but keep them there; but we could stop admissions.

Mrs. ROGERS. Where are these veterans going that are not service-connected? Many of them are potentially service-connected cases.

General HINES. Well, I doubt very much whether a man who is rated these days, if he has any disability, in view of the great improvement in the records, and the quickness with which those records reach our board—83 percent of men discharged for disability from the service are being placed on the pension rolls. That is a very high percentage of rating.

Mr. SCRIVNER. That is a higher batting average than 25 years ago.

Mrs. ROGERS. We have not any legislation yet for consumptives; undoubtedly we will do that later, and that will take care of a large number of non-service-connected cases.

General HINES. I do not think you need legislation for consumptives, because the cases are being rated on better records, and more promptly, to these special boards; they are going on pension rolls very fast.

I would like to give the committee some information on World War II ratings, up to date.

On March 31, 1945, we had rated living veterans, and placed on the pension roll, 433,849.

For death pensions, 67,462.

Now, from March to May 31, that number had increased so that you had service-connected cases of living veterans of 499,619. Those, added to the non-service-connected, for World War II alone, 492, brought the total to 500,111.

With death service connected cases of 84,989, and non-service connected, 141, we have the total of 85,130.

In other words, on May 31, on the pension or compensation rolls of the Veterans' Administration were 1,095,786 living veterans.

Widows, or dependents of deceased veterans, 349,706.

Now that does not include, of course, awards made on insurance; under the national service insurance, on the same date, May 31, we had allowed claims for 199,412. The amount of the insurance award—that is the liability for that—was \$1,801,783,900. That is all World War II that I am telling you about, as to the insurance.

Some of the insurance had already been converted, for some of the men who had come out of the service, and also some death cases, of course, had been paid off.

While I hesitate to put too much in the record, Mr. Chairman, I think a copy of this statement should be furnished every member of the committee, and I will be glad to see that that is done.

The CHAIRMAN. Why not insert it in the record?

General HINES. I will be glad to, if you feel it should, because it contains more information on what is going on and will give the committee a fair appraisal of the other activities of the Veterans' Administration, which we have heard very little about. We have talked about hospitals, which are a very important thing; to me it has always been what I consider to be the greatest benefit the Congress has ever given to the serviceman, and for that reason I would hesitate

to see any denial of hospital facilities, but I cannot help but agree with Congressman Scrivner that, if we have not the personnel, it is dangerous to undertake to take patients into our hospitals and try to treat them.

Mrs. ROGERS. Your accidents happen when you have a shortage of nurses.

General HINES. Well, nurses too, of course.

The CHAIRMAN. Without objection, that statement may be inserted in the record.

(The statement referred to is as follows:)



## Insurance—death and disability (cases on which claims have been adjudicated)

	Nov. 30, 1941				Mar. 31, 1945				Apr. 30, 1945				May 31, 1945			
	War-risk term and automatic		U. S. Government life		War-risk term and automatic		U. S. Government life		War-risk term and automatic		U. S. Government life		War-risk term and automatic		U. S. Government life	
	Death	Disability	Death	Disability	Death	Disability	Death	Disability	Death	Disability	Death	Disability	Death	Disability	Death	Disability
Total adjudicated.....	224,017	35,726	65,173	16,024	224,323	35,676	82,171	16,848	224,333	35,670	82,565	16,829	224,339	35,668	83,073	16,810
Allowed.....	180,207	15,933	49,031	13,197	180,569	15,941	65,994	13,989	180,579	15,936	66,388	13,969	180,585	15,934	66,896	13,949
Active.....	7,588	10,324	8,321	10,743	2,092	9,608	12,718	10,858	1,963	9,575	12,808	10,837	1,843	9,559	12,932	10,817
Terminated.....	11,435	4,457	10	2,165	11,604	5,057	26	2,740	11,604	5,076	26	2,741	11,608	5,088	26	2,741
Payment of cases completed.....	161,134	1,152	40,700	289	166,873	1,276	53,250	391	167,012	1,285	53,554	391	167,134	1,287	53,938	391
Lump sum.....	52,334	1,152	36,047	289	52,884	1,276	47,040	391	52,893	1,285	47,309	391	52,901	1,287	47,654	391
Installments expired.....	108,769		4,651		113,907		6,208		114,037		6,243		114,151		6,282	
Funds escheating to Government.....	81		2		82		2		82		2		82		2	
Disallowed.....	43,810	19,793	16,142	2,827	43,754	19,735	16,177	2,859	43,754	19,734	16,177	2,860	43,754	19,734	16,177	2,861

## U. S. Government life insurance policies

	Nov. 30, 1941		Apr. 30, 1945		May 31, 1945	
	Number	Amount	Number	Amount	Number	Amount
Applications received.....	1,185,879		1,213,810		1,214,100	
Applications approved to date.....	1,117,626	\$4,640,615,906	1,138,993	\$4,787,144,195	1,139,176	\$4,788,213,846
Insurance in force: <sup>1</sup>						
Ordinary life.....	140,674	698,999,162	140,166	701,742,798		
20-payment life.....	221,725	779,089,664	211,913	759,652,065		
30-payment life.....	28,581	146,209,671	28,400	147,264,798		
20-year endowment.....	69,795	187,873,604	54,092	145,052,498		
30-year endowment.....	28,636	121,317,085	27,940	119,523,066		
Endowment at age 62.....	29,598	139,866,024	28,890	136,300,902		

5-year convertible term:					
Duration less than 5 years.....	3	23,000			
Duration more than 5 years (whole life, 745).....	22,064	128,314,533	20,761	120,293,608	
Renewed:					
Second period.....	3,888	27,012,710	3	16,000	
Third period.....	16,529	108,386,162	4,487	29,498,813	
Fourth period.....			12,167	79,680,402	
5-year level premium term:					
Duration less than 5 years.....	19,284	125,659,609	18,680	140,902,476	
Renewed:					
Second period.....	5,079	26,883,122	6,500	37,633,351	
Third period.....			2,172	11,457,562	
Extended insurance.....	15,636	45,270,342	10,522	29,558,839	
Paid-up life.....	2,655	4,379,118	2,792	4,989,289	
Paid-up endowment.....	858	901,683	673	757,346	
Total.....	605,005	2,540,185,489	570,158	2,464,323,813	

<sup>1</sup> Tabulation for current month not available.

## National service life insurance (cases on which claims have been allowed)

	Nov. 30, 1941		Mar. 31, 1945		Apr. 30, 1945		May 31, 1945	
	Number	Amount of insurance	Number	Amount of insurance	Number	Amount of insurance	Number	Amount of insurance
Allowed.....	401	\$1,963,420	170,971	\$1,530,027,100	185,650	\$1,671,346,300	199,412	\$1,801,783,900
Active.....	401	1,963,420	170,540	1,527,093,800	185,216	1,668,379,000	198,973	1,798,778,600
Life annuity.....	337	1,646,420	132,739	1,177,291,100	144,088	1,286,073,100	152,928	1,368,488,900
240 installments.....	58	282,000	31,328	288,303,500	34,153	315,876,400	38,261	355,962,500
Life annuity and 240 installments.....	6	35,000	6,473	61,499,200	6,975	66,429,500	7,784	74,327,200
Payments terminated.....			393	2,623,300	392	2,625,300	393	2,631,300
Awarded claims canceled.....			38	310,000	42	342,000	46	374,000

## National service life insurance policies

	Nov. 30, 1941		Mar. 31, 1945		Apr. 30, 1945		May 31, 1945	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
Applications received.....	719,428		17,179,267		17,375,098		17,574,431	
Applications approved to date.....	682,195	\$2,331,451,000	116,960,546	\$120,936,206,500	217,138,128	\$131,603,365,500	317,365,258	\$133,755,726,500
Applications disapproved to date.....	11,741	46,743,821	90,305	418,112,688	91,429	425,486,188	492,524	432,870,188
Insurance in force: <sup>1</sup>								
5-year level premium term.....	656,020	2,276,249,472	15,977,410	122,905,393,906	15,949,963	123,087,823,776		
Ordinary life.....			9,492	61,627,500	11,160	71,284,500		
20-payment life.....			52,943	300,356,179	62,416	347,123,179		
30-payment life.....			9,350	63,859,929	10,946	73,588,929		
Total.....	656,020	2,276,249,472	16,049,195	123,331,237,513	16,034,485	123,579,820,384		

<sup>1</sup> Includes radio applications: 12,499, \$40,932,500.<sup>2</sup> Includes radio applications: 12,501, \$40,932,500.<sup>3</sup> Includes radio applications: 12,505, \$49,990,500.<sup>4</sup> Includes radio applications: 2.<sup>5</sup> Tabulation for current month not available.

## Soldiers' and Sailors' Civil Relief Act of 1940

	Nov. 30, 1941		Mar. 31, 1945		Apr. 30, 1945		May 31, 1945	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount
Applications received.....	17,540		101,268		101,796		102,579	
Applications approved.....	13,026	\$34,347,787.02	85,658	\$213,558,482.74	86,079	\$214,649,920.74	86,469	\$215,692,386.00
Applications rejected.....	3,291	7,159,577.55	14,501	33,389,220.65	14,584	33,612,897.65	14,653	33,761,551.65





## Beneficiaries receiving hospital treatment or domiciliary care authorized by Veterans' Administration

Branch of service, facility, or hospital	Nov. 30, 1941				Mar. 31, 1945				Apr. 30, 1945				May 31, 1945			
	Serv-ice con-nected	Non-service con-nected	Non-Vet-erans' Ad-minis-tration	Total	Serv-ice con-nected	Non-service con-nected	Non-Vet-erans' Ad-minis-tration	Total	Serv-ice con-nected	Non-service con-nected	Non-Vet-erans' Ad-minis-tration	Total	Serv-ice con-nected	Non-service con-nected	Non-Vet-erans' Ad-minis-tration	Total
Veterans' Administration	12,468	42,912	215	55,595	22,161	43,237	274	65,672	22,689	44,099	287	67,075	22,549	43,596	279	66,424
Federal Security Agency:																
Marine	32	784	2	818	50	721	1	772	43	775	2	820	54	703		757
St. Elizabeths Hospital	50	31		81	51	25		76	50	25		75	48	25		73
Army	150	641	1	792	100	646		746	102	607		709	96	553		649
Navy	46	861	1	908	116	1,120	2	1,238	111	1,184	2	1,297	107	1,171	1	1,279
Civil and State	304	731	5	1,040	472	870	5	1,347	447		5	1,290	405	862	5	1,332
Total hospital treatment	13,050	45,960	224	59,234	22,950	46,619	282	69,851	23,442	47,528	296	71,266	23,319	46,910	285	70,514
Domiciliary care: Veterans' Administration	961	14,848		15,809	621	8,827		9,448	591	8,564		9,155	591	8,271		8,862
Grand total, hospital and domiciliary care	14,011	60,808	224	75,043	23,571	55,446	282	79,299	24,033	56,092	296	80,421	23,910	55,181	285	79,376

NOTE: Figures for observation for compensation, pensions, or insurance, and temporary hospitalization included in nonservice connected.

## Authorized beds in all Veterans' Administration facilities

	Nov. 30, 1941				May 31, 1945			
	Hospital				Hospital			
	Tuber-culosis	Psy-chotic	Other neuro-psychi-atric	General	Total	Domicil-iary	Grand total	
In operation	5,193	33,364	2,538	20,750	61,845	18,725	80,570	94,359
Work in progress		463		799	1,262	71	1,333	14,276
Total	5,193	33,827	2,538	2,549	63,107	18,796	81,903	108,735

*Active pension and compensation cases, all wars and regular establishment*

	Nov. 30, 1941		Mar. 31, 1945		Apr. 30, 1945		May 31, 1945	
	Living veterans	Deceased veterans	Living veterans	Deceased veterans	Living veterans	Deceased veterans	Living veterans	Deceased veterans
War of 1812 (special act).....		1		1		1		1
Mexican War:								
Public acts.....		93		56		55		54
Special acts.....		9		4		4		4
Total, Mexican War.....		102		60		59		58
Indian Wars:								
Public acts.....	1,840	3,717	1,146	2,664	1,123	2,658	1,112	2,642
Special acts.....	37	57	18	44	18	43	18	43
Total, Indian Wars.....	1,877	3,774	1,164	2,708	1,141	2,701	1,130	2,685
Civil War:								
Public acts.....	1,236	37,453	263	22,886	248	22,708	236	22,552
Special acts.....	15	3,667	3	2,299	3	2,249	3	2,192
Total, Civil War.....	1,251	41,120	266	25,185	251	24,957	239	24,744
Spanish-American War:								
Service connected.....	1,476	1,301	1,138	1,211	1,138	1,210	1,134	1,208
Nonservice connected.....	149,378	60,151	128,638	69,883	128,161	69,962	127,498	70,335
Special acts.....	73	139	61	108	61	108	61	105
Total, Spanish-American War.....	150,927	61,591	129,837	71,202	129,360	71,280	128,693	71,648
World War I:								
Service connected.....	349,455	96,022	333,321	85,278	333,002	84,757	332,811	84,410
Nonservice connected.....	76,636	23,616	88,656	32,605	89,066	54,906	89,654	66,984
Special acts.....			2		2		2	
Total, World War I.....	426,093	119,638	421,979	117,883	422,070	139,663	422,467	151,394
Regular establishment:								
Public acts.....	38,140	11,003	42,531	13,471	42,578	13,763	42,539	13,788
Special acts.....	652	344	611	260	608	200	607	258
Total, Regular Establishment.....	38,792	11,347	43,142	13,731	43,186	14,023	43,146	14,046
World War II:								
Service connected.....			433,849	67,462	465,777	74,665	499,619	84,989
Nonservice connected.....			375	90	426	100	492	141
Total, World War II.....			434,224	67,552	466,203	74,765	500,111	85,130
Total pensions and compensation.....	618,940	237,573	1,030,612	298,322	1,062,211	327,449	1,095,786	349,706

NOTE.—Figures reported under Living and Deceased Veterans of All Wars prior to Spanish-American War represent number of regular monthly payments.

*Emergency officers' retirement, World War I*

	Nov. 30, 1941	Mar. 31, 1945	Apr. 30, 1945	May 31, 1945
Emergency officers entitled to retirement pay.....	2,951	3,044	3,044	3,044
Receiving retirement pay.....	2,637	2,499	2,490	2,484
Retirement pay suspended:				
Under sec. 212, Public No. 212, 72d Cong.....	36	33	33	33
Active duty.....	3	27	27	27
Incompetent, estate over \$1,500.....	8	7	7	7
Terminated by death.....	267	478	487	493

*Retired Reserve officers*

	Nov. 30, 1941	Mar. 31, 1945	Apr. 30, 1945	May 31, 1945
Reserve officers entitled to retirement pay.....	5	4,764	5,663	7,380
Receiving retirement pay.....	5	4,697	5,589	7,285
Retirement pay suspended:				
Under sec. 212, Public, No. 212, 72d Cong.....		17	22	26
Active duty.....		6	7	8
Incompetent.....		1	1	1
Request of War Department.....		5	5	8
Veteran's renouncement of retirement pay.....		8	8	8
Terminated by death.....		30	31	40

*Burial awards during month*

	Novem- ber 1941	March 1945	April 1945	May 1945
World War I.....	2,433	2,873	2,770	3,357
World War II.....		410	385	410
Spanish-American War, Philippine Insurrection, Boxer Rebel- Sion.....	479	466	464	566
Civil war.....	30	12	10	13
Indian wars.....	17	12	11	6
Regular Establishment.....	32	25	31	30
Other wars.....	13	2		
Total.....	3,004	3,800	3,671	4,390

*Vocational rehabilitation (Public Law 16, pt. VII)*

	Aug. 31, 1943	Mar. 31, 1945	Apr., 30, 1945	May 31, 1945
Cases in file.....	1,742	61,598	67,391	74,119
Applications approved pending induction.....	192	3,320	3,815	4,678
Applications approved declined induction.....	46	2,360	2,480	2,704
In training.....	48	13,477	14,478	15,078

*Education and training (Public Law 346, pt. VIII)*

	Aug. 31, 1944	Mar. 31, 1945	Apr. 30, 1945	May 31, 1945
Number of cases in file (Form 1950).....	7,819	60,421	66,862	74,260
Number eligible for training (allowed).....	5,647	53,710	60,391	67,549
Number in training.....	442	21,001	23,552	24,164

*Guardianship (incompetent veterans, other incompetents, and minors)*

	Nov. 30, 1941	Mar. 31, 1945	Apr. 30, 1945	May 31, 1945
Fiduciaries:				
Guardians.....	57,502	55,299	55,554	55,999
Legal custodians.....	10,144	12,829	13,402	14,181
Institutional awards only.....	593	967	1,015	1,038
Total.....	68,239	69,095	69,971	71,218
Wards:				
Under guardians.....	66,416	61,904	62,194	62,754
Institutional awards only.....	593	967	1,015	1,038
Under legal custodians.....	15,695	19,408	20,200	21,486
Total.....	82,704	82,279	83,409	85,278



*Out-patient medical activities*

	Novem- ber 1941	March 1945	April 1945	May 1945
Number of individuals receiving out-patient treatment during month.....	25, 195	29, 669	29, 204	30, 441
Number of individuals examined during month.....	27, 288	54, 509	51, 523	55, 475
Pensions and compensation.....	5, 315	27, 484	26, 161	28, 696
Insurance.....	657	610	541	569
Determination of need of hospital or domiciliary care.....	11, 916	18, 222	16, 700	17, 650
Out-patient treatment (veterans).....	6, 608	5, 985	6, 177	6, 370
Vocational rehabilitation.....		404	291	375
Out-patient (others).....	844	439	456	632
Civil Service Commission.....	1, 042	921	811	798
Employees' Compensation Commission.....	92	126	77	82
Allied pensions.....	27	22	21	18
Work Projects Administration.....	45			
Railroad Retirement.....	207	157	156	177
Army.....	506	68	61	64
Navy.....	8	48	55	29
Other Government departments or agencies.....	13	23	16	15
Civilian Conservation Corps.....	8			

*Personnel on roll (excluding purchase and hire and \$1 per annum employees)*

	Nov. 30, 1941	Mar. 31, 1945	Apr. 30, 1945	May 31, 1945
Central offices:				
Washington, D. C.....	6, 133	6, 459	6, 782	7, 004
New York branch.....		6, 422	6, 617	7, 105
Field offices.....	38, 663	43, 534	44, 608	45, 892
Total, salaries and expenses appropriation.....	44, 796	56, 415	58, 007	60, 001
Central office, hospital and domiciliary appropriation.....	34	210	213	214

Mr. SCRIVNER. General, perhaps I misunderstood you, but I thought you made a statement to the effect that 83 percent of the men discharged have been placed on compensation rolls.

General HINES. 83 percent of the men discharged on a certificate of disability.

Mr. SCRIVNER. Oh, 83 percent of those?

General HINES. Yes. In other words, the papers are sent to these area boards and rated by the area boards; 83 percent of those have gone on the rolls.

Mr. SCRIVNER. Now you made reference to pension rolls. Is it all considered as pension now?

General HINES. No. World War I is still compensation, with service-connected cases.

Mr. SCRIVNER. Well, do you not think, as a matter of psychology, that all of our laws should read that where it is service-connected—in other words, where a man is absolutely entitled to it—that it should be considered as compensation, as distinguished from your non-service-connected disability, where that is really an out-and-out gratuity of the Government, that can well be called a pension?

General HINES. We have legislation before this committee which will correct it, and do just exactly that.

Mr. SCRIVNER. I am glad of that, because I think it has hurt some of these men. They do not like to be called pensioners when they are merely being paid something to which they are entitled as a matter of service-connected disability.

General HINES. I am sure there is that feeling, and for that reason we have included a provision in a bill which is now before the committee which will do exactly that.

Mrs. ROGERS. At what rate are you service-connecting cases of World War I at the present time?

General HINES. Well, I think those claims come in at about the rate of 1,000 per month, but how many are allowed I do not know.

Mrs. ROGERS. They come in, and are rated, I know, because old records are filed, and I am amazed at the number.

General HINES. Perhaps I can answer your question. No, this would not answer your question, Mrs. Rogers, because the difference between 1 month and next year would include deductions for deaths, so I will have to get that information for you and place it in the record.

Mrs. ROGERS. I think it is important, General. Certainly the public wants the veterans hospitalized. I am sure of that.

General HINES. I will submit the information for the record.

(The information is as follows:)

*Disability and death cases with claims for compensation or pension, where veteran had service on or after Dec. 7, 1941, in file end of month (World War II)*

## DISABILITY CASES (WORLD WAR II)

Month	Total cases in file		Pending, end of month	Total adjudicated				Cases adjudicated				Allowed		Disallowed																																																																																																																																																																																																																																					
	Net in- crease during month	To date		Net increase during month	To date		Net increase during month	To date		Net in- crease during month	To date	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent monthly increase adjudi- cated	Total adjudi- cated	Percent of total in file	Number	Percent

## DEATH CASES (WORLD WAR II)

June 1944	3,322	48,878	9,063	2,906	87.5	38,915	79.6	2,340	80.5	28,700	73.8	596	10,215
July	3,677	52,555	10,025	3,015	98.3	42,530	80.9	3,048	84.3	31,748	74.6	597	10,782
August	5,037	57,392	11,160	3,962	77.5	46,432	80.6	3,275	83.9	33,023	75.4	627	11,409
September	6,088	64,208	13,200	4,640	69.4	51,072	79.5	3,984	85.9	33,007	76.4	656	12,065
October	7,407	71,687	15,638	4,957	66.9	56,029	78.2	4,102	84.0	43,169	77.0	795	13,860
November	7,845	79,332	18,068	4,835	61.6	60,864	76.5	3,965	82.0	47,134	77.4	870	15,730
December	8,155	87,687	21,237	5,586	68.5	66,450	75.8	4,800	85.9	51,924	78.2	785	17,510
January 1945	7,048	94,735	22,597	5,088	80.7	72,138	76.1	4,924	86.6	56,858	78.9	704	18,210
February	7,041	101,776	22,739	6,869	98.0	79,037	77.6	6,042	87.6	62,900	79.6	857	19,137
March	13,802	115,278	28,440	7,801	57.8	86,838	75.3	6,733	86.3	69,633	81.1	1,068	17,205
April	10,626	125,904	30,938	8,128	76.5	94,966	75.4	7,385	90.9	77,018	81.1	743	17,948
May	10,450	136,354	29,815	11,573	110.7	106,539	78.1	10,509	90.8	87,527	82.2	1,064	19,012



General HINES. But it is surprising that even at this late date we get good claims.

Mr. SCRIVNER. I am surprised that you have a thousand per month.

General HINES. That is not allowed, but claims filed.

Mrs. ROGERS. But you have a good many allowed?

General HINES. Yes.

Mr. McQUEEN. Mr. Chairman, may I ask a question?

The CHAIRMAN. Yes.

Mr. McQUEEN. Under the present system, General Hines, approximately how long does it take to adjudicate a claim for disability of a man of World War II? Under present working conditions?

General HINES. Those claims are all adjudicated in the area boards. If the records are sent, as instructions of the War and Navy Departments contemplate, on the same day the man is discharged, the average rate at which they are adjudicating those cases in the area boards is less than 5 days.

Mr. McQUEEN. Five days?

General HINES. Yes.

Mr. McQUEEN. Now may I ask the same question with respect to insurance claims?

General HINES. Insurance claims are taking longer, because generally the insurance claims, of course, are death claims, and sometimes, if the death occurs in the South Pacific, it may be 39 or 40 days before we even get the case. Those cases are coming down but they are taking too long. I would imagine, from the time they hit the Veterans' Administration, at any point, after the verification of the question of whether premiums have been paid, they take as many as between 40 and 50 days.

Mr. McQUEEN. Is that from the actual date of death, or the date on which you are notified?

General HINES. The date on which we are notified. It would take that long. There is a considerable lag. I have data prepared which I will be glad to furnish. I thought probably, when you got to taking up other cases, that you would like to have Major Clark and Mr. Breining, who are in charge of those divisions, testify and give you the exact data from their charts.

Mr. McQUEEN. Thank you.

(Mr. Breining has a statement and it has been requested that he furnish it by 9 a. m. Monday.)

General HINES. The nine area offices of the Veterans' Administration, one located in each Army command, adjudicate disability pension claims in from 1 to 5 days, on the average, following receipt of service and medical record, accompanied by application for disability pension from the War and Navy Departments, or from the regional offices of the Veterans' Administration. That is where a claim is filed by a man who has been discharged from the service, where he was discharged on a certificate of disability, it would go to the area board; where he goes and files a claim either at the discharge center or at the regional office, the regional office would handle it.

Regional offices of the Veterans' Administration, whose jurisdiction includes claims filed by persons who are discharged for reasons other than disability, or where the disabled service man or woman is discharged directly to a Veterans' Administration facility for further treatment, are adjudicating claims on the average of approximately 2½ months from the date of receipt of the pension claim.

Every effort is being made to reduce the elapsed time, although there is a certain amount of delay where supplemental service records or further medical data in the form of examinations are required.

I might say that the reexamination of these men is one of the main causes for delay.

Every effort has been made to reduce the minimum period of time which elapses between the date of receipt of a claim for death pension or compensation and the date of final action.

The large number of claims received, and the complicating factors incident to the lack of adequate personnel, have of course increased the difficulty of attaining this objective. In addition the enactment of mandatory liberalized laws has necessitated the review and adjudication of a large number of claims, particularly under Public Law 242 and Public Law 483, wherein certain rates of the Spanish War have been increased.

But in the case of the South Pacific, which is the one with the longest delay, it is due to the fact that those records do not reach us from the service departments until after a considerable lapse of time. The last I saw was, I think, 39 days.

Mr. McQUEEN. Then, of course, there is a lapse of probably 60 to 90 days before the notification?

General HINES. No, that is from the date of death until the service department gives us some notice.

Now there is another delay that has been rather hard to correct. We send the forms to the widows, but they are apparently in no hurry to get them back to us. There is a lapse, there, of considerable time, before we can really act on them at all.

Mr. McQUEEN. General Hines, there is another question I would like to ask you about these area boards. Perhaps you would rather have some of your assistants answer it. In the case of the man who is sent to the area board, and then comes to the Veterans' Administration for reexamination, have you found that your area boards have been altogether successful, even though they have been quick in the adjudication or the granting of the claim?

General HINES. I would say they have, in the great majority of cases. Originally they were accused of being too liberal in their awards, but I think that, at the rate they are going now, and with the few changes that are being made in the awards, that their ratings are satisfactory.

Mr. McQUEEN. Well, under the original regulations under which they were working, and under the regulations that had been set down, and the laws of the Veterans' Administration, did you not find trouble, there, with reductions in a great many of those awards?

General HINES. After they were reexamined?

Mr. McQUEEN. Yes.

General HINES. Well, I also attach some of that change in the rating to the difference in the examination upon which the area board acted, as against the examination made by our own people. In other words, we rate initially on the examination made by the Army and Navy, and of course that may not be as complete as the examination or the test as to whether the disability existed prior to enlistment, as it would be in our own regional offices.

Mr. McQUEEN. Well, over all, then, would you still recommend that the area board be maintained for quick service to the veterans, or discontinued?



General HINES. No, I think it should be maintained until we are over the peak.

Now, Mrs. Rogers, with reference to one of your previous questions, I may say that Colonel Livingstone did not go with the Army. He is still going to work up there in connection with the West Roxbury facility.

Mrs. ROGERS. It is not Colonel Livingstone; I do not mean the one who was at West Roxbury. I mean the man who was trained by Doctor Monroe at the Boston City Hospital, in neurosurgical work.

General HINES. There seems to be a question of fees involved.

Mrs. ROGERS. Oh yes, I know. He is doing his work there for nothing, General Hines. He is not charging anything.

General HINES. Monroe is, but the other doctor.

Mrs. ROGERS. He was the man, you know, who by his work enabled a very fine baseball player to play baseball again.

General HINES. Yes, I recall that.

Mrs. ROGERS. Of course the boys are tremendously anxious to get to this hospital. And he was responsible for the training of a doctor in neurosurgical work at the Virginia Army Hospital.

General HINES. Yes. Mr. Chairman, I feel now that I would like to answer any questions the members of the committee may have. I could go on, here, for months, talking about various activities, but I think it would be a repetition of what we have in the record, whereas there may be some important questions to be answered.

Mrs. ROGERS. I have a question, Mr. Chairman.

The CHAIRMAN. Mrs. Rogers.

Mrs. ROGERS. General Hines, how long did you say it took to rate cases?

General HINES. Well, on the area boards, on the examinations, when the men are discharged from the Army, and those papers are sent to the area boards, from 1 to 5 days.

In the case of death claims, and that is the case of claims that take the longest time, there is a lapse of all the way from 30 to 39 days before the case notification comes to us.

After it reaches us, it will depend a good deal on how rapidly the beneficiary returns the papers which are sent to him.

Mrs. ROGERS. One hundred and fifty days has been given as the time required.

General HINES. Well, it has been as high as that, but generally out of the 150 days, 60 or 90 may be in delay from wherever the death occurred. But it is going down. I will have the exact statement for the committee on that, because we have been making a survey.

(The statement referred to is as follows:)

The attached chart shows the results of two spot-checks, the first made on May 25, 1945, and the second on July 14, 1945. Therefrom it is shown that the total elapsed time from date of death to date of award has increased due, as shown by the chart, to an increase and delay in—

1. Receiving report of death from the Army or Navy;
2. Filing of claim and supporting evidence by claimant; and
3. Forwarding of mail to Adjudicating Service by Administration Mail and Record Service.

However, as will be noted, the time required by the Veterans' Administration to process the cases; that is, secure the claim and evidence, adjudicate the claim and award payment, has been reduced from an average of 100.15 days to 89.77 days, while the time not attributable to the Veterans' Administration has increased from 60.59 days to 80.55 days.



Notwithstanding this, the reports for the month of June 1945 show the death pension claims are now being adjudicated at a rate in excess of the number received, thus reducing the balance of pending claims by approximately 4,000 for the month.

	Time for report of death to reach Veterans' Administration	Time for report of death to move from mail room to Dependents Claims Service	Time for application to be sent claimant by claims Service	Time for application to be returned by claimant	Time for application to move from mail room to Dependents Claims Service	Time to make award	Average number days from death to award	Time required by Veterans' Administration
Spot check, May 25, 1945	35.0	19.9	14.14	25.59	22.57	43.54	160.74	100.15
Spot check, July 14, 1945	47.87	18.91	4.15	32.68	26.66	40.05	170.32	89.77

Similar results are revealed by the following detailed study of insurance cases:

## OFFICE MEMORANDUM, UNITED STATES GOVERNMENT

To: Executive Assistant to the Administrator.

JULY 17, 1945.

From: Mr. Breining, Assistant Administrator.

Subject: Spot checks on time required to adjudicate claims.

The following report based upon 200 death settlements, subsequent to April 25, 1945, shows the average and median <sup>1</sup> of elapsed time from date of death to date of initial payment, and elapsed time for completion of the various intervening operations (cases selected at random):

	Average	Median <sup>1</sup>
1. Number of days from date of death to date notice of death is received in Veterans' Administration	35	29
a. Army	32	
b. Navy	58	
c. Discharge	8	
2. Number of days from date notice of death received in Veterans' Administration to date notice received in Insurance Service with XC file	25	25
a. <sup>2</sup> Days from completion of 207 procedure to date premium information (368) received in Insurance Service (median 14)	18	
b. Days between completion of 207 procedure to date XC file received in Insurance Service	15	
3. Number of days from date XC file received in Insurance Service to date first letter sent to beneficiary	9	
a. Days to complete insurance work sheet	6	
4. Number of days from date first letter to beneficiary to date complete evidence received in Veterans' Administration	35	24
5. Number of days from date complete evidence received in Veterans' Administration to date same received in Insurance Service	14	13
6. Number of days from receipt of complete evidence in Insurance Service to date award sent to Finance Service	13	11
a. Award submitted after receipt of evidence in Insurance Service	4	
b. Time between submission and approval	3	
c. Time between approval and date sent to Finance	6	
7. Number of days from date award sent to Finance to date referred to Treasury for payment	4	4
8. Number of days from date award sent to Treasury to date check released	3	3
9. Number of days from date of death to date check released	138	117

<sup>1</sup> Median—The one hundredth and one hundred first cases if all 200 cases were arranged in order of elapsed time in handling from the shortest to the longest. The median is a safer guide since extreme cases do not affect it disproportionately.

<sup>2</sup> Item 2a is overlapped by period shown as Item 2.

A break-down of the foregoing report shows that the average time for action by the various services and beneficiaries is as follows (figures in parentheses indicate median):

	<i>Elapsed days</i>
Service Department (item 1) (claimant in discharge cases).....	35 (29)
Chief Clerk (items 2 and 5).....	39 (38)
Beneficiary (item 4).....	35 (24)
Insurance Service (items 3 and 6).....	22 (19)
Finance Service (item 7).....	4 (4)
Treasury Department (item 8).....	3 (3)

The foregoing report reveals three items over which the Veterans' Administration has no control: 35 (29) days for Service Department to report death; 35 (24) days for the beneficiary to complete evidence after necessary forms and instructions have been mailed to him; 3 (3) days for Treasury to issue check. Disregarding these items the remaining 65 (61) days represent the amount of time during which the Veterans' Administration is handling the case. The amount of time after the beneficiary completes his evidence to date of payment is 31 (28) days.

A further analysis of the cases was made to determine the longest and shortest period for accomplishing essential operations and how the remainder of the cases were handled in relation to the average time figure.

*Service Departments (item 1).*—Number of days from date of death to date notice of death received in Veterans' Administration (including notice by claimants). The longest period was 208 days, the shortest 3 days.

Number of cases from—

0 to 9 days.....	5
10 to 19 days.....	27
20 to 29 days.....	71
30 to 39 days.....	39
40 or more.....	58

*Chief Clerk's Service (items 2 and 5).*—Number of days from date notice of death received in Veterans' Administration to date received in Insurance Service. The longest period was 87 days, the shortest 5 days.

Number of cases from (item 2)—

0 to 9 days.....	3
10 to 19 days.....	35
20 to 29 days.....	117
30 to 39 days.....	26
40 or more.....	19

Number of days from date receipt complete evidence in Veterans' Administration to date same received in Insurance Service. The longest period was 107 days, the shortest 0 days.

Number of cases from (item 5)—

0 to 9 days.....	66
10 to 19 days.....	111
20 to 29 days.....	10
30 to 39 days.....	4
40 or more.....	9

*Beneficiary (item 4).*—Number of days from first letter to beneficiary to date complete evidence received in Veterans' Administration. The longest period was 305 days, the shortest 0 days.

Number of cases from—

0 to 9 days.....	33
10 to 19 days.....	44
20 to 29 days.....	48
30 to 39 days.....	18
40 or more.....	57

*Insurance Service (items 3 and 6).*—Number of days from date XC file received in Insurance Service to date first letter sent to beneficiary. The longest period 93 days; the shortest 0 days.

## Number of cases from (item 3):

0 to 9 days	116
10 to 19 days	69
20 to 29 days	12
30 to 39 days	0
40 or more	3

Number of days from date receipt complete evidence in Insurance Service to date award sent to Finance for payment. The longest period 80 days, the shortest 0 days.

## Number of cases from (item 6):

0 to 9 days	84
10 to 19 days	95
20 to 29 days	8
30 to 39 days	6
40 or more	7

*Finance Service (items 2a and 7).—*Number of days from completion of 207 procedure to date premium information (Form 368) received in Insurance Service. The longest period 216 days, the shortest 3 days.

## Number of cases from (item 2a)—

0 to 9 days	40
10 to 19 days	127
20 to 29 days	15
30 to 39 days	3
40 or more	13

NOTE.—Two aviation cadet cases—Forms 368 not located in file.

Number of days from date award sent to Finance to date sent to Treasury for payment. The longest period 17 days, the shortest 0 days.

## Number of cases from (item 7)—

0 to 9 days	174
10 to 19 days	5
20 to 29 days	0
30 to 39 days	0
40 or more	0

NOTE.—Twenty-one case records not available for inspection at time of survey. Since the range is so limited it is very improbable that the 21 records would affect the results.

*Treasury (item 8).—*Number of days from date voucher sent to Treasury to date payment released. The longest period 13 days, shortest 0 days.

## Number of cases from—

0 to 9 days	175
10 to 19 days	4
20 to 29 days	0
30 to 39 days	0
40 or more	0

NOTE.—Twenty-one case records not available for inspection at time of survey. Since the range is so limited it is very improbable that the 21 records would affect the results.

The settlement of claims is speeded up by the prevailing policy which waives all formal proof of relationship (except in cases where spouse is beneficiary and either party was previously married) and age in settling the claims of designated beneficiaries. The general practice is to accept the statement of such beneficiary for the purpose of making tentative settlement. He is required to execute only his formal claim and select the mode of settlement.

The table appearing on page 6 reveals that the first letter to the beneficiary was released by the central office on an average of 4 days (3 days median) less time than the New York office. Both offices completed adjudication after the claim was received in the same amount of time. The total for both of the foregoing items is 20 days (17 median) for the central office and 24 days (20 median) for the New York office.

HAROLD W. BREINING,



ADDENDA.—Average and median—Comparison between New York (140 cases) and Washington (60 cases <sup>1</sup>)

	Average		Median	
	N.Y.	D.C.	N.Y.	D.C.
1. Number of days from date of death to date notice of death is received in Veterans' Administration.....	33	41	28	33
2. Number of days from date notice of death received in Veterans' Administration to date notice received in Insurance Service with XC file.....	23	31	24	29
Days <sup>2</sup> from completion of 207 procedure to date premium information (368) received in Insurance Service.....	17-20			
Median.....	14-13			
3. Number of days from date XC file received in Insurance Service to date first letter sent to beneficiary.....	11	7	9	6
4. Number of days from date first letter to beneficiary to day complete evidence received in Veterans' Administration.....	37	30	28	15
5. Number of days from date complete evidence received in Veterans' Administration to date same received in Insurance Service.....	14	13	17	6
6. Number of days from receipt of complete evidence in Insurance Service to date award sent to Finance Service.....	13	13	11	11
7. Number of days from date award sent to Finance to date referred to Treasury for payment.....	4	4	4	4
8. Number of days from date award sent to Treasury to date check released.....	3	3	4	3
9. Number of days from date of death to date check released.....	138	142	124	107

<sup>1</sup> Includes 9 special contact cases.

<sup>2</sup> Item 2a overlapped by item 2.

Mrs. ROGERS. I felt that if you had been a Cabinet member, General Hines, that you could have secured some of the personnel from the alphabetical agencies for this work.

General HINES. Well, the great difficulty is that if those agencies are cutting down very much, the personnel is going somewhere else. But I will say that the clerical positions in Washington are practically all filled, and we have now reached the point where space is the controlling factor. We cannot put on any more personnel in the central office until we get more space in Washington.

Mrs. ROGERS. There, again, if you were a member of the Cabinet, you would get your space.

General HINES. Well, I am getting the space now, I think.

Mrs. ROGERS. But everything is too late.

General HINES. You may be entirely right. Perhaps I have not been as aggressive in becoming a member of the Cabinet as I should have been, or in recommending that it be set up as a Department, but I want to say that every President, including this President, has certainly helped whenever I have gone to him for help.

Mrs. ROGERS. But you have had to wait a long time. For instance, you had to wait a long time before you could secure any doctors from the Army.

General HINES. Yes. I have. But I can readily understand why that would happen. I think if I had been a member of the General Staff Corps, and the Surgeon General were telling me he needed five or six thousand more doctors and 10,000 more nurses, I would have hesitated to do anything to stop that flow of personnel.

Mrs. ROGERS. They wanted you to have your own corps, did they not?

General HINES. Yes.

Mrs. ROGERS. That was true also of the Army and Navy. General Hines, do you not think that we would perhaps have more interest generally, and that the House would be more interested in hospital

legislation and care of the men if we went back to the old system of having this World War Veterans' Committee recommending general areas for hospital sites? If we had more meetings with doctors, and so on?

General HINES. Well, I doubt very much whether you could locate hospitals more rapidly than the Board could do it.

Mrs. ROGERS. Well the whole Congress knew more about it at that time, and I think it would be better if the Congress were more interested.

General HINES. I do recommend to the committee, however, that at more frequent intervals, the Administrator of Veterans' Affairs be called before the committee to indicate what progress is being made.

Mrs. ROGERS. I agree with you.

General HINES. I have been appearing right along, and I have always been glad to appear, and have tried to keep the committee advised. But in the last 2 years, the amount of work that has fallen upon that office has been just too much to do it all.

Mrs. ROGERS. Well we had no doctors appearing before our committee.

General HINES. You had some last week.

Mrs. ROGERS. I mean up to that time.

General HINES. Of course, the committee can have anyone appear before it at any time, whether you are conducting an investigation or not. I am sure you are familiar with the attitude I have always taken. There was no one on the staff of the Veterans' Administration, or any data that I would not gladly furnish to the committee, and I have been very appreciative of the cooperation this committee has given me.

Mrs. ROGERS. You do have the worst job in Washington, General Hines, outside of the Army and Navy.

General HINES. That is one reason Congressman Scrivner's question this morning made it more difficult for me to answer, because I believe, probably, even though I had violated the procedure laid down on legislation, that if I had come to the committee, it would have been helpful. I might have shortened the process.

Mr. SCRIVNER. Well, there are a great many agencies here, and I am sure there is not one member of this committee that would have felt the least bit harshly toward you if you had, and I am sure none of us would have violated any confidence you had given us.

General HINES. I am convinced of that.

Mrs. ROGERS. Sometimes the head of a department hesitates about coming unless he has Presidential sanction. But of course we could have called you on these matters, and I tried to get hearings on the Medical Corps and on other matters for a number of years. We discussed that a great many times.

General HINES. Yes; I know. And I knew something of what was coming when you and I were discussing the bill. I knew that we were bound to have some revamping of the medical set-up, and of other parts of the Veterans' Administration, because, mind you, it has grown, in the last year, by 8,000 additional.

Mrs. ROGERS. Yes, I know; but I think we ought to have seen that coming, if we had any vision at all. We knew the number in the Army, the number of casualties we were likely to have.

General HINES. I wonder if the committee has taken notice of a move I made with respect to the nurses—and I might say that I did

this on my own responsibility, and not with the full concurrence of the Civil Service Commission—by making a change in the grades from subprofessional to professional for the nurses in the Veterans' Administration, and in that connection I shall be glad to let the committee have this bulletin.

(The bulletin is as follows:)

VETERANS' ADMINISTRATION,  
Washington 25, D. C., June 24, 1945.

To: All stations.

Subject: Reallocation of Positions of Nurse.

(Personal attention.)

DEAR SIR: Based upon a classification survey and reevaluation of the duties involved in certain medical subprofessional positions in the field service, specifications for the several levels of responsibility found in the following-named positions have been revised as indicated in the attached copies under titles shown below:

3 levels—GM or TB under 1,000 beds, NP under 2,000 beds:		4 levels—GM or TB 1,000 beds or more, NP 2,000 beds or more:	
Chief nurse.....	P-3	Chief nurse.....	P-4
Assistant chief nurse.....	P-2	Assistant chief nurse.....	P-3
Assistant to chief nurse.....		Assistant to chief nurse.....	P-2
Operating-room supervisor.....	P-2	Operating-room supervisor.....	P-2
Head nurse.....	P-2	Head nurse.....	P-2
Nurse.....	P-1	Nurse.....	P-1
Nursing arts supervisor <sup>1</sup> .....	P-3	Nursing arts supervisor <sup>1</sup> .....	P-3
Assistant nursing arts supervisor <sup>1</sup> .....	P-2	Assistant nursing arts supervisor <sup>1</sup> .....	P-2

<sup>1</sup> Applicable only at stations where currently authorized.

Immediately upon receipt of this communication, these standards should be carefully considered by all concerned and particularly by the members of the local classification committee. Current classification sheets of all authorized positions of nurse should be reviewed and survey made of the duties involved in each position. New prototypal classification sheets will be prepared and submitted to this office accurately reflecting present functions and responsibilities in order that all necessary adjustments in grade may be effected as contemplated on July 1, 1945. In preparing the classification sheets, the administrative position numbers required under item No. 7 of the classification form must be indicated. Under no circumstances will any reallocations of currently authorized positions be made until you are specifically advised to do so.

This action does not contemplate the establishment of additional positions or the realignment of functions of existing authorized positions at this time. The immediate objective is to readjust present positions in accordance with the new specification as such positions are now functioning. Requests for new and additional positions should be submitted separately for each type of position required in the usual manner with supporting justification as need arises.

Revised standards covering the following-named positions will follow at an early date:

Dietitian  
Social worker  
Librarian  
Recreational director

Physical therapy technician  
Occupational therapy aides  
Laboratorian (bacteriological)  
Laboratorian (X-ray)

Very truly yours,

G. H. SWEET,  
Director of Personnel.

Nurse, P-1

In a hospital, serves as nurse on rotating assignment, by shift, and ward, clinic, or operating room duty.

I. On a ward assignment, under the supervision of a head nurse performs the following duties and assumes the following responsibilities:

Gives nursing care to patients. Takes and charts temperature, pulse, and respiration at specified times. Pours, administers, and charts prescribed medications. Administers and records prescribed treatments, or assists physician with treatments, involving setting up and operating a variety of apparatus and equipment as required. Changes dressings or assists physician in applying dressings.



Sets up surgical carts and trays. Follows prescribed techniques in pre- and post-operative care of patients. Prepares or supervises preparation of patients for special tests and examinations. Records patients' conditions at specified time or as necessary.

Attends to personal comfort and well being of patients. Bathes bedridden patients. Attends to or supervises attendance to personal hygiene of patients. Checks diet orders with trays from dietetic service. Serves or supervises serving of trays at mealtimes and between-meal nourishments, and feeds or supervises feeding of helpless patients. Makes or supervises making of beds and changes of bed linens. Distributes mail.

In the nursing care and attendance to personal comfort of neuropsychiatric patients follows hospital security measures; encourages participation in group therapy activities; trains or supervises training of regressed or deteriorated patients in personal hygiene and habits; observes and records symptoms and reactions; supervises feeding of patients in ward or main dining rooms; records or supervises recording of count of patients at specified intervals, restraint or seclusion applied as ordered by physician, any disturbance, injuries, or accidents occurring on ward, and number of patients engaged in work detail; and arranges for patients' clothing to be cleaned, repaired, and replaced.

Maintains records and prepares reports incident to nursing care, comfort, and personal hygiene of patients, and cleanliness of ward. As assigned, assists with administrative details such as transfer or discharge of patients, appointment with and routing of patients to clinics, laboratories, or other services in the hospital for treatment, diagnostic tests, examination or interview, arrangement for patients' effects and clinical folder to be available in case of death, and issuance of comfort articles to indigent patients, or patients' funds to specified patients.

II. On a clinic assignment, under the supervision of the chief nurse and by direction of clinic physicians, sterilizes and sets up instruments and supplies required in various examination or treatment procedures; maintains stock of supplies in clinic, preparing monthly requisitions, checking on receipt, and storing articles properly; as required, assists physician during examination or treatment of patients; records clinic visit of patients; and supervises the cleaning of clinic rooms.

III. On operating room assignment, under the supervision of the operating room supervisor is responsible for aseptic and surgical nursing techniques preparatory to and during operations. Stores or supervises storing of surgical instruments and supplies. Prepares surgical supplies for sterilization. Prepares solutions. Sterilizes surgical supplies, including linen, instruments, solutions, and containers. When participating in operations, either selects and lays out surgical instruments and linens as indicated by type of operation to be performed, hands all sterile instruments to surgeon as anticipated or by request, and counts sponges and dressings, or observes performance of these tasks by another nurse, checking on sponge and dressing count, noting contamination of sterile instruments and supplies and disposing of such contaminated articles, and sees that all necessary surgical supplies are available. Prepares specimens for routing to laboratories. Supplies details for nurse's portion of operation record.

On rotating assignment, serves as nurse in charge of a ward where chronic or less acute medical conditions or less acute surgical conditions are treated; or, under the general supervision of the chief nurse or the immediate supervision of a head nurse, serves as nurse in charge of a ward where neuropsychiatric conditions are treated; in either case is responsible for nursing care and comfort of patients, care and sanitation of supplies, equipment, furnishings, space utilized, and the maintenance of required records and reports. On a neuropsychiatric ward is responsible for adherence to security measures and safety regulations; training of attendants in the application of psychotherapeutic methods; the training or supervision of training of patients who are regressed or deteriorated in good habits of personal cleanliness and conduct; observation and noting of actions of patients, particularly those on "special observation" status; the encouragement of patients' participation in group therapy activities; arranging for conducting groups of patients to recreational activities, or fitting into ward schedule various recreational activities on the ward; and supervision of feeding of patients in ward or main dining rooms.

Specifies work assignments of staff nurses and/or attendants. Supervises staff nurses and/or attendants engaged in providing nursing care and attending to personal hygiene, comfort and feeding of patients, care and sanitation of supplies, equipment, and furnishings, cleaning the ward, and preparing required records and reports. Instructs new employees in their assigned duties. Rates efficiency of employees supervised.

Compares nurses' notes with ward physician's notes for each 24-hour period. Observes nursing care given, care and sanitation of ward, and care of supplies and equipment, by making rounds alone or with chief nurse or head nurse and ward physician. Confers with, and reports incidents or problems to chief nurse, or to head nurse if so supervised, or ward physician.

Schedules or supervises scheduling of appointments for patients with clinics, laboratory, or other services for treatment, diagnostic tests, or interview. Arranges or supervises arrangement of patients' attendance, accompanied or unaccompanied, at the clinics, laboratory, other services, or recreational activities. Receives or supervises reception of patients transferred to ward involving assignment of bed, contacting ward physician, and arranging for storage of clothing and custody of other personal articles or funds. Discharges or supervises discharge of patients to another ward, or for trial visit or final discharge from hospital. In case of death arranges for patients' effects and clinical folder to be available for ward physician's inspection, and notifies chief nurse.

Prepares or reviews preparation of, consolidates, and forwards to proper destination, requisitions for drugs and supplies, orders for work or repairs, orders for regular or therapeutic diets and nourishments, orders for comfort articles for specified patients, and orders for cleaning, repair, or replacement of patients' clothing. Notes daily recording of alcoholics and narcotics used, and compiles monthly report of their use. Prepares or reviews preparation of records involving transfers of patients to and from ward, for discharge or trial visit or upon death. Receives patients' mail and sees that it is delivered.

As assigned, participates in orientation and staff education programs for nurses and in-service training program for attendants, or where applicable, in student nurse training programs, by lecturing on specified subjects or giving on-the-job demonstrations.

On rotating assignment, on evening or night shifts, serves as nurse in charge of nursing activities of any medical or surgical ward, or in a neuropsychiatric hospital, of a group of wards.

Performs other duties as assigned.

#### *Head nurse, P-2*

In a hospital where the conditions treated and the number of patients require nurses at three levels of responsibility, serves as nurse in charge of a ward where acute medical or acute surgical conditions are treated, or where patients are received, and on rotating assignment is in charge of nursing activities on evening or night shifts.

On day duty, under the supervision of the chief nurse, is responsible for the nursing care and comfort of patients, care and sanitation of supplies, equipment, furnishings, and space utilized, and the maintenance of required records and reports.

Specifies work assignments of nurses and attendants. Supervises nurses and attendants engaged in providing nursing care and attending to personal hygiene, comfort, and feeding of patients, care and sanitation of supplies, equipment, and furnishings, cleaning the ward, and preparing required records and reports. Instructs new employees in their assigned duties. Rates efficiency of employees supervised.

Compares nurses' notes with ward physician's notes for each 24-hour period. Observes nursing care given, care and sanitation of ward, and care of supplies and equipment by making rounds unaccompanied or with chief nurse or ward physician. Confers with and reports incidents, or problems, to chief nurse or ward physician.

Schedules or supervises scheduling of appointments for patients with clinics, laboratories, or other services for treatment, diagnostic tests, or interview. Arranges or supervises arrangement of patient's attendance, accompanied or unaccompanied, at the clinics, laboratories, other services, or recreational activities. Receives or supervises reception of patients transferred in, involving assigning bed, contacting ward physician, and arranging for storage of clothing and custody of other personal articles or funds. Discharges or supervises discharge of patients to another ward, or for trial visit or final discharge from hospital. In case of death arranges for patients' effects and clinical folder to be available for ward physician's inspection, and notifies chief nurse.

Prepares or reviews preparation of, consolidates, and forwards to proper destination requisitions for drugs and supplies, orders for work or repairs, orders for regular or therapeutic diets and nourishments, orders for comfort articles for specified patients, and orders for cleaning, repair, or replacement of clothing for specified patients. Notes daily recording of alcoholics and narcotics used, and



compiles monthly report of their use. Prepares or reviews preparation of records involving transfers of patients to and from ward, for discharge or trial visit, or upon death. Receives patients' mail and sees that it is delivered.

As assigned, participates in orientation and staff education programs for nurses and in-service training programs for attendants, or where applicable, in student-nurse-training programs, by lecturing on specified subjects or giving on-the-job demonstrations.

On rotating assignment, on evening or night shift, serves as nurse in charge of nursing activities of any ward.

On rotating assignment, on evening or night shift, under the supervision of the chief nurse, and by direction of the medical officer serving as officer of the day, is responsible for the nursing care of patients throughout the hospital, involving making rounds for observance of functioning of wards, conferring with nurses and attendants in supervisory positions, and making decisions for action in emergency or unusual situations, assigning of nurses or attendants for special duty in care of critically ill patients, and performance of administrative detail, such as reviewing or preparing records, reports, requisitions, and consolidating reports and records.

On relief assignment, serves in the capacity of assistant chief nurse or chief nurse.

Performs other duties as assigned.

#### *Head nurse, P-2*

In a hospital where the conditions treated and the number of patients require nurses at four levels of responsibility, serves as nurse in charge of a ward where acute medical or acute surgical conditions are treated, or where patients are received, and on rotating assignment is in charge of nursing activities on the night shift.

On day duty, under the supervision of the chief nurse is responsible for the nursing care and comfort of patients, care and sanitation of supplies, equipment, furnishings, and space utilized, and the maintenance of required records and reports.

Specifies work assignments of nurses and attendants. Supervises nurses and attendants engaged in providing nursing care and attending to personal hygiene, comfort, and feeding of patients, care and sanitation of supplies, equipment, and furnishings, cleaning the ward, and preparing required records and reports. Instructs new employees in their assigned duties. Rates efficiency of employees supervised.

Compares nurses' notes with ward physician's notes for each 24-hour period. Observes nursing care given, care and sanitation of ward, and care of supplies and equipment by making rounds unaccompanied or with chief nurse or ward physician. Confers with and reports incidents, or problems, to chief nurse, or ward physician.

Schedules or supervises scheduling of appointments for patients with clinics, laboratories, or other services for treatment, diagnostic tests, or interview. Arranges or supervises arrangement of patients' attendance, accompanied or unaccompanied, at the clinics, laboratory, other services, or recreational activities. Receives or supervises reception of patients transferred in, involving assigning bed, contacting ward physician, and arranging for storage of clothing and custody of other personal articles or funds. Discharges or supervises discharge of patients to another ward, or for trial visit or final discharge from hospital. In case of death arranges for patients' effects and clinical folder to be available for ward-physician's inspection, and notifies chief nurse.

Prepares or reviews preparation of, consolidates, and forwards to proper destination requisitions for drugs and supplies, orders for work or repairs, orders for regular or therapeutic diets and nourishments, orders for comfort articles for specified patients, and orders for cleaning, repair, or replacement of clothing for specified patients. Notes daily recording of alcoholics and narcotics used, and compiles monthly report of their use. Prepares or reviews preparation of records involving transfers of patients to and from ward, for discharge or trial visit, or upon death. Receives patients' mail and sees that it is delivered.

As assigned, participates in orientation and staff education programs for nurses and in-service training program for attendants, or where applicable, in student nurse training programs, by lecturing on specified subjects or giving on-the-job demonstrations.

On rotating assignment on evening or night shifts serves as nurse in charge of nursing activities of any ward.



On rotating assignment, on night shift, under the supervision of the chief nurse, and by direction of the medical officer serving as officer of the day, is responsible for the nursing care of patients throughout the hospital, involving making rounds for observance of functioning of nursing service on wards, conferring with nurses and attendants in supervisory positions, making decisions for action in emergency or unusual situations, assigning nurses or attendants for special duty in care of critically ill patients, and performance of administrative detail, such as reviewing or preparing records, reports, and requisitions, and consolidating reports and records.

On relief assignment, services in the capacity of assistant chief nurse of second assistant chief nurse.

Performs other duties as assigned.

#### *Head nurse, P-2*

In a neuropsychiatric hospital requiring nurses at three levels of responsibility, serves as nurse in charge of a group of wards where conditions of the same general classification are treated, and on rotating assignment, is in charge of nursing activities of the entire hospital on evening or night shifts.

On day-duty, under the supervision of the chief nurse, is responsible for the nursing care and comfort of patients, adherence to security measures and safety regulations, cooperation with other services in encouraging patients' participation in occupational therapy and recreational activities, care and sanitation of supplies, equipment, furnishings, and space utilized, and maintenance of required records and reports on the group of wards. By frequent rounds of wards and review of ward records, observes nursing care and comfort of patients, adherence to security measures, psychiatric methods utilized, and care and sanitation of supplies, equipment, furnishings, and space utilized.

Specifies work assignments of nurses and attendants. Instructs or supervises instruction of new employees in their assignments. Rates efficiency of employees supervised.

Prepares, or reviews preparation of, consolidates, and forwards to proper destination work or repair orders; requisitions for supplies or equipment; requisitions for drugs; diet orders; records of occupational therapy details, count of patients, disturbance or accidents of patients, issuance of comfort articles, cleaning, repair, or replacement of clothing, transfers in, transfers out, discharges, deaths.

As assigned, participates in orientation and staff education programs for nurses and in-service training program for attendants, or where applicable, in student-nurse-training program, by lecturing on specified subjects or giving on-the-job demonstrations.

On evening or night duty, under the supervision of the chief nurse, and by direction from the medical officer serving as officer of the day, is responsible for nursing care of patients throughout the hospital. Makes rounds to observe ward activities, reporting findings. Confers with nurses and attendants in supervisory positions, making decisions for action in emergency or unusual situations. Assigns nurses or attendants for special care for critically ill patients. Rearranges work assignments as required by absence of employees or increased activity on wards. Performs administrative work, such as reviewing or preparing records, reports, or requisitions, and consolidating reports and records.

On relief assignment, serves in the capacity of assistant chief nurse or chief nurse.

Performs other duties as assigned.

#### *Head nurse, P-2*

In a neuropsychiatric hospital requiring nurses at four levels of responsibility, serves as nurse in charge of a group of wards where conditions of the same general classification are treated, and on rotating assignment, is in charge of nursing activities of the entire hospital on the night shift.

On day duty, under the supervision of the chief nurse, is responsible for the nursing care and comfort of patients, adherence to security measures and safety regulations, cooperation with other services in encouraging patients' participation in occupational therapy and recreational activities, care and sanitation of supplies, equipment, furnishings, and space utilized, and maintenance of required records and reports on the group of wards. By frequent rounds of wards and review of ward records, observes nursing care and comfort of patients, adherence to security measures, psychiatric methods utilized, and care and sanitation of supplies, equipment, furnishings, and space utilized.

Specifies work assignments of nurses and attendants. Instructs or supervises instruction of new employees in their assignments. Rates efficiency of employees supervised.

Prepares, or reviews preparation of, consolidates, and forwards to proper destination work or repair orders; requisitions for supplies or equipment; requisitions for drugs; diet orders; record of occupational therapy details, count of patients, disturbance or accidents of patients, issuance of comfort articles, cleaning, repair, or replacement of clothing, transfers in, transfers out, discharges, deaths.

As assigned, participated in orientation and staff education programs for nurses and in-service training program for attendants, or where applicable, in student-nurse-training program, by lecturing on specified subjects or giving on-the-job demonstrations.

On night duty, under the supervision of the chief nurse, and by direction from the medical officer serving as officer of the day, is responsible for nursing care of patients throughout the hospital. Makes rounds to observe ward activities, reporting findings. Confers with nurses and attendants in supervisory positions, making decisions for action in emergency or unusual situations. Assigns nurses or attendants for special care for critically ill patients. Rearranges work assignments as required by absence of employees or increased activity on wards. Performs administrative work, such as reviewing or preparing records, reports, or requisitions, and consolidating reports and records.

On relief assignment, serves in the capacity of second assistant chief nurse or assistant chief nurse.

Performs other duties as assigned.

#### *Operating-room supervisor, P-2*

In a hospital where the daily operating room schedule covers regularly two major operations occurring simultaneously, serves as operating room supervisor on a full-time day assignment.

Under the supervision of the chief nurse, and by direction from chief of surgical service or surgeons, is responsible for supervision and instruction of nurses and attendants in aseptic and surgical nursing techniques; care and sanitation of all supplies, equipment, furnishings, and space utilized in operating and accessory rooms; and the maintenance of records and reports.

Specifies work assignments of nurses and attendants. Instructs and supervises nurses in the selection and placement of instruments and equipment as indicated by the type of operation to be performed in the number, variety, and order in which instruments will be requested during operations, and in aseptic techniques to be followed; or in observance of details to be noted during operation, such as checking and disposal of contaminated articles, sponge and dressing counts, availability of instruments or linens, recording of operation details, and preparation and routing of specimens. Instructs and supervises attendant in care of patient to and from operating room, in posturing patient for operation, and in cleaning room during and after operation.

Supervises attendants engaged in cleaning all equipment, furnishings, and space in operating room suits. Performs or supervises performance of the preparation of solutions for sterilizing, preparation of linen and other supplies for sterilizing, the sharpening of instruments, and the sterilization of all supplies used in the operation. Prepares or reviews preparation of specimens and nurses' portion of operation records. Prepares or reviews preparation of requisitions for expendable supplies. Consults with surgeon regarding serviceability of instruments, and arranges for repair or replacement when necessary. Rates efficiency of nurses and attendants assigned to operating room.

When participating in an operation, observes sponge and dressing count, contamination of sterile instruments or supplies, disposing of such articles, and availability of all necessary instruments; prepares or supervises preparation of specimens and routes to laboratory; and supplies required details of nursing portion of operation record.

As assigned, participates in orientation and staff education programs for nurses and in-service training for attendants, or where applicable, student nurses training programs, by lecturing on specified subjects or giving on-the-job demonstrations.

Performs other duties as assigned.

#### *Assistant to chief nurse, P-2*

In a hospital where the conditions treated and the number of patients require nurses at four levels of responsibility, serves as second assistant to the nurse in charge of the nursing service on day duty, and as evening supervisor of the nursing service on rotating assignment.



On day duty, under the supervision of the chief nurse has responsibility for observing quality and functioning of nursing care of patients, and care and sanitation of hospital by periodic rounds and inspection tours of a regularly assigned portion of the hospital, conferring with medical office and nurses or attendants in supervisory positions, and reporting findings. As assigned, assists with administrative work of the nursing service, including review of ward, 24-hour reports and periodic review of ward records, changing assignments on time schedules as required, preparing requisitions for supplies and equipment, and preparing records and reports.

On evening duty, under the supervision of the chief nurse and by direction from the medical officer serving as officer of the day, supervises the entire nursing service, involving the observance of quality and functioning of nursing service, and care and sanitation of the hospital by regular rounds over the entire hospital, conferring with supervisory nurses and attendants, making decisions for action in emergency or unusual situations, assigning nurses for special care of critically ill patients, and reporting any unusual incidents to the chief nurse. Performs administrative work as assigned, including review of 24-hour ward reports and periodic review of ward records, preparation of requisitions, and required reports.

In the staff education and orientation programs for nurses and the in-service training program for attendants, and where applicable, in the student-nurse training program, gives classroom instruction in specified subjects.

On relief assignment, assumes responsibilities of assistant chief nurse.

Performs other duties as assigned.

#### *Assistant chief nurse, P-2*

In a hospital where the conditions treated and the number of patients require nurses at three levels of responsibility, serves as assistant to the nurse in charge of the nursing service.

Under supervision of the chief nurse, is regularly assigned to day duty, except for relief assignments for evening or night duty with responsibility for supervision of nursing care of patients during those periods.

On day duty, assists with direction and supervision of the nursing care of patients; the care and sanitation of the hospital (except space utilized by the dietetic service); the management of nurses' and attendants' living quarters; the maintenance of records and reports required in the nursing and housekeeping activities; the management of all personnel engaged in the nursing service and housekeeping activities; the formulation and operation of staff education and orientation programs for nurses and in-service training program for attendants; and where applicable, the integration and coordination of a student nurse training program within the nursing service.

Alternates with nurse in charge in observing quality and functioning of nursing service, and care and sanitation of hospital by periodic rounds and inspection tours, conferring with medical officers and nurses or attendants in supervisory positions, and reports findings. Assists with review of ward 24-hour reports and periodic review of ward records. Assists with administrative work, including changing assignments on time schedules as required; interviewing applicants for all positions in nursing and housekeeping services and recommending selection of attendants, maids, charwomen, and janitors; rating efficiency of employees supervised; preparing requisitions for supplies and equipment; and preparing records and reports.

In the nurses' staff education and orientation programs, and attendants' in-service training program, and where applicable, in student nurse training program, gives classroom instruction on specified subjects.

Serves as nurse in charge of the nursing service in the absence of the chief nurse.

Performs other duties as assigned.

#### *Assistant chief nurse P-3*

In a hospital where the conditions treated and the number of patients require nurses at four levels of responsibility, serves as principal assistant to the nurse in charge of the nursing service.

Under supervision of the chief nurse, is regularly assigned to day duty, except for relief assignments for evening or night duty with responsibility for supervision of nursing care of patients during those periods.

On day duty, assists with direction and supervision of the nursing care of patients; the care and sanitation of the hospital (except space utilized by the dietetic service); the management of nurses' and attendants' living quarters; the maintenance of records and reports required in the nursing and housekeeping activities; the management of all personnel engaged in the nursing service and housekeeping



activities; the formulation and operation of staff education and orientation programs for nurses and in-service training for attendants, and where applicable, the integration and coordination of a student nurse training program within the nursing service.

Alternates with chief nurse and with the second assistant chief nurse in observing quality and functioning of nursing service, and care and sanitation of hospital by periodic rounds and inspection tours, conferring with medical officers and nurses or attendants in supervisory positions, and reporting findings. Assists with review of 24-hour ward reports and periodic review of ward records. Assists with administrative work, including changing assignments on time schedules as required, interviewing applicants for all positions in the nursing service and housekeeping activities, and recommending selection of attendants, maids, charwomen, and janitors; rating efficiency of employees supervised; preparing requisitions for supplies and equipment, and preparing records and reports.

In the nurses' staff education and orientation programs, and attendants' in-service training program, and where applicable, in student nurse training program, gives classroom instruction on specified subjects.

Serves as nurse in charge of the nursing service in the absence of the chief nurse. Performs other duties as assigned.

### *Chief Nurse, P-3*

In a hospital where the conditions treated and the number of patients require nurses at three levels of responsibility, serves as nurse in charge of the nursing service.

Under the supervision of the clinical director or the chief medical officer and subject to the regulations of and procedural direction from the central office of the Veterans' Administration, is responsible for the nursing care of patients; the care and sanitation of the hospital, except space utilized by the dietetic service; the management of quarters occupied by nurses, attendants, or other specified personnel; the maintenance of records and reports required in nursing service and housekeeping activities; the management of all personnel engaged in the nursing service and housekeeping activities, the formulation and operation of staff education and orientation program for nurses, and in-service training programs for attendants; and, where applicable, the integration and coordination of a student-nurse training program within the nursing service.

Specifies work assignments of nurses, attendants, housekeepers, janitors, charwomen, and maids. Interviews applicants for all positions in the nursing and housekeeping service and selects attendants, maids, charwomen, and janitors. Prepares time schedules for nursing duty by ward and shift. Reviews time schedules prepared by the supervisor of attendants for attendant duty by ward and shift. Prepares yearly annual-leave schedules, and approves interim leave requests. Rates or reviews rating of efficiency of all employees supervised.

Assigns living accommodations to nurses in quarters on station. Supervises housekeepers or maids and janitors engaged in cleaning quarters occupied by nurses and attendants. Prepares or reviews requisitions for supplies, equipment, and work or repairs to be accomplished in living quarters. Orders food from dietetic service for nurses ill in quarters or off duty. Visits nurses and attendants ill in quarters and calls physician when necessary.

Observes quality and functioning of nursing service and care and sanitation of hospital, by means of periodic rounds and inspection tours, 24-hour reports from nurses in charge of wards and services, periodic review of ward records, and consultation with medical officers and nurses or attendants in supervisory positions. Resolves any questions or problems concerning nursing-service functions.

Prepares or reviews requisitions for supplies and equipment in stock, and consults with medical officers concerning need for supplies and equipment not on schedule, or regarding space requirements. Maintains control records on specified hospital items. Prepares or reviews reports and records required.

Formulates orientation and staff education programs for nurses and in-service training for attendants, lecturing, or arranging for lectures or practical demonstrations by medical officers, nurses, attendants, or other employees engaged in allied treatment or service activities; where applicable, develops or supervises development of student-nurse training program, including classroom instruction by medical officers and nurses, and ward, clinic, or operating-room assignments of the student nurses.

Attends hospital staff conferences. By means of periodic conferences with nursing staff maintains and stimulates staff's interest in developments in the nursing field growing out of advances in medical science.

Performs other duties as assigned.

*Chief nurse, P-4*

In a hospital where the conditions treated and the number of patients require nurses at four levels of responsibility, serves as nurse in charge of the nursing service.

Under the supervision of the clinical director or the chief medical officer and subject to the regulations of and procedural direction from the central office of the Veterans' Administration, is responsible for the nursing care of patients; the care and sanitation of the hospital, except space utilized by the dietetic service; the management of quarters occupied by nurses, attendants, or other specified personnel; the maintenance of records and reports required in nursing service and housekeeping activities; the management of all personnel engaged in the nursing service and housekeeping activities; the formulation and operation of staff education and orientation programs for nurses and in-service training program for attendants; and, where applicable, the integration and coordination of a student nurse training program within the nursing service.

Specifies work assignments of nurses, attendants, housekeepers, janitors, charwomen, and maids. Interviews applicants for all positions in the nursing and housekeeping service and selects attendants, maids, charwomen, and janitors. Prepares time schedules for nursing duty by ward and shift. Reviews time schedules prepared by supervisor of attendants for attendant duty by ward and shift. Prepares yearly annual leave schedules and approves interim leave requests. Rates or reviews rating of efficiency of all employees supervised.

Assigns living accommodations to nurses in quarters on station. Supervises housekeepers or maids and janitors engaged in cleaning quarters occupied by nurses and attendants. Prepares or reviews requisitions for supplies, equipment, and work or repairs to be accomplished in living quarters. Orders food from dietetic service for nurses ill in quarters or off duty. Visits nurses and attendants ill in quarters and calls physician when necessary.

Observes quality and functioning of nursing service, and care and sanitation of hospital by means of periodic rounds and inspection tours, 24-hour reports from nurses in charge of wards and services, periodic review of ward records, and consultation with medical officers, and nurses or attendants in supervisory positions. Resolves any questions or problems concerning nursing-service functions.

Prepares or reviews requisitions for supplies and equipment in stock, and consults with medical officers concerning need for other supplies and equipment, or regarding space requirements. Maintains control records on specified hospital items. Prepares or reviews reports and records required.

Formulates staff education and orientation programs for nurses and in-service training program for attendants, lecturing or arranging for lectures or practical demonstrations by medical officers, nurses, attendants, or other employees engaged in allied treatment or service activities. Where applicable, develops or supervises development of student-nurse-training program including classroom instruction by medical officers and nurses, and ward, clinic, or operating-room assignments of the student nurses.

Attends hospital staff conferences. By means of periodic conferences with nursing staff maintains and stimulates staff's interest in developments in the nursing field growing out of advance in medical science.

Performs other duties as assigned.

Mrs. ROGERS. I introduced a bill for that, as you know, General Hines, but to date Mr. Rankin has not given me a hearing on it. But you feel that legislation is not necessary now?

General HINES. That is right.

Mrs. ROGERS. That the Civil Service will back you up?

General HINES. Yes.

Mrs. ROGERS. Of course, the President could do it and could have done it long ago by Executive order.

General HINES. I doubt if the President could have done it by Executive order.

Mrs. ROGERS. Why not? You can do it, General Hines, and he has, under the special authority, always been able to blanket people into various positions.

General HINES. Well, I had the feeling that the Civil Service would not raise the issue on the change of classification between the field and Washington.



Mrs. ROGERS. The President always has the authority to blanket certain persons in under Civil Service?

General HINES. Yes.

I might say to Congressman Scrivner, who asked about the later salaries, that recently I started, with one of the members of the Investigation Division, to check up on the rates of pay of the Veterans' Administration employees.

Mr. SCRIVNER. I think that would be interesting to have, because if there has been any discrimination, it has not been fair.

General HINES. Yes. Here is a note that comes to me on that:

The following represents the general conclusions of Mr. Hiller from the report of Mr. Gallbraith, of the investigation; Post-classification procedure did not keep up with our rapidly changing organization, but during the year we did reclassify over a thousand jobs covering all grades and involving a large number of employees. This process continues with the expansion of our activities. In the lower classification grade, the average pay may be a little less than in other agencies. The Civil Service Commission is approving 97 percent of our recommendations as opposed to 90 percent for other agencies, and this situation is vastly improving.

Mr. SCRIVNER. That indicates, then, that you have been working under a disadvantage insofar as your rates of pay and your higher classifications are concerned?

General HINES. Yes, I admitted that.

Now I think this table which I have here, on the classifications, which represents a record that has been kept recently at my direction, showing where the Classification Committee of the Civil Service did not approve the grade recommended by us, might be interesting to the committee. This list contains, I should say, about 30 names, where the grade recommended by us, over various types of personnel, from professional to clerical, was refused approval by Civil Service.

That does not necessarily mean that we were right in all those cases. They may be right. But it does show a disposition, at the time this record was made, toward not being very liberal in classification.

Mrs. ROGERS. Is that only for 30 cases?

General HINES. It is only part of them.

Mr. McQUEEN. May we put that in the record?

Mr. CARNAHAN (acting chairman). Without objection.

(The list is as follows:)

*Positions not approved by Civil Service Commission as to grade allocation by administrator*

Title of position	Service	Grade recommended by Administrator	Grade approved by Commission
Secretary to Assistant Chief, National Service Life Insurance Subdivision (vacant; code V-1).	Insurance.....	CAF-4-310....	CAF-3-310
Secretary to Assistant Chief, Converted Insurance Subdivision (vacant; code V-1).	do.....	CAF-4-310....	CAF-3-310.
Secretary to executive officer (restatement: Davis, Nina E.)	Medical.....	CAF-6-310....	CAF-5-310.
Chief, Statistical Operation Subdivision (restatement: Decker, Leona).	Budget and statistics.....	CAF-9-1520...	CAF-8-1520.
Assistant to Chief (restatement: Ganey, Honora)	Insurance (Insurance Claims Council).	CAF-9-130....	CAF-7-130.
Communications clerk.....	Finance employees' accounts).	CAF-3-420....	CAF-2-420.
Statistical clerk.....	Budget and statistics.....	CAF-5-1520...	CAF-4-1520.
Secretary to Chief of Change and Correspondence Subdivision.	Insurance (Actuarial and Insurance Policy, New York Branch.).	CAF-4-310....	CAF-3-310.



*Positions not approved by Civil Service Commission as to grade allocation by administrator—Continued*

Title of position	Service	Grade recommended by Administrator	Grade approved by Commission
Engineering draftsman.....	Construction.....	SP-7-830	SP-6-830.
Assistant Chief, Administrative Reports Subdivision.....	Budget and statistics.....	CAF-8-1520	CAF-7-1520.
Correspondence clerk.....	Dependents' Claims, Field Supervision.....	CAF-4-330	CAF-3-330.
Chief, Research Section.....	Insurance.....	CAF-13-1240	CAF-12-1240.
Assistant Chief, Research Section.....	do.....	CAF-12-1240	CAF-11-1240.
Supervisor Legislative Records and Research.....	Solicitor.....	CAF-9-130	CAF-8-680.
Assistant Supervisor, Legislative Records and Research.....	do.....	CAF-7-130	CAF-6-680.
Supervisor.....	Administrative office.....	CAF-7	CAF-6.
Investigator.....	Investigation.....	CAF-13	CAF-12.
Cost accounting clerk.....	Budget and statistics.....	CAF-6	CAF-5.
Assistant Chief, Tabulating Machine Section.....	do.....	CAF-5	CAF-4.
Assistant to Chief, Hospital Records Section.....	do.....	CAF-5	CAF-4.
Statistical clerk.....	do.....	CAF-3	CAF-2.
Assistant to Chief, Hospital Records Section.....	do.....	CAF-5	CAF-4.
Chief, Field Records Division.....	Chief Clerk's office.....	CAF-10	CAF-9.
Assistant Chief, Field Records Division.....	Chief Clerk.....	CAF-8	CAF-7.
Assistant Chief Clerk.....	do.....	CAF-12	CAF-11.
Supervisor, Duplicating Section.....	do.....	CPC-6	CAF-4.
Stenographer.....	do.....	CAF-3	CAF-2.
Clerk-stenographer.....	do.....	CAF-3	CAF-2.
Assistant supervisor of carpenters.....	do.....	CPC-7	CPC-6.
Supervisor, Administrative Issue Section.....	do.....	CAF-4	CAF-3.
Principal classifier:			
Policy Files Section.....	do.....	CAF-4	CAF-3.
General name files.....	do.....	CAF-4	CAF-3.
Personnel Files Subdivision.....	do.....	CAF-4	CAF-3.
General Files Section.....	do.....	CAF-4	CAF-3.
Personnel record clerk.....	do.....	CAF-3	CAF-2.
Secretary to Chief, Index Division.....	do.....	CAF-4	CAF-3.
Principal classifier (incoming mail).....	do.....	CAF-4	CAF-3.
Stenographer.....	do.....	CAF-4	CAF-3.
Chief, Records Disposal Section.....	do.....	CAF-6	CAF-5.
Executive secretary.....	do.....	CAF-4	CAF-3.
Chief, General Names Files Subdivision.....	do.....	CAF-6	CAF-5.
Assistant Chief, General Name Files Subdivision.....	do.....	CAF-5	CAF-4.
Chief, Policy Files (Section, General Records Division).....	do.....	CAF-5	CAF-4.
Assistant Chief, M Street Files Subdivision.....	do.....	CAF-6	CAF-5.
Chief, Administration and Policy Subdivision.....	do.....	CAF-6	CAF-5.
Multilith Cameraman and Plate Maker.....	do.....	CAF-4	CAF-3.
Mechanic.....	do.....	CPC-7	CPC-6.
Chief, Distribution Subdivision.....	do.....	CAF-6	CAF-5.
Assistant Chief, Index Division.....	do.....	CAF-10	CAF-9.
Messenger, Publication Division.....	do.....	CPC-3	CPC-2.
Chief, Communications Division.....	do.....	CAF-11	CAF-10.
Assistant Chief, Communications Division.....	do.....	CAF-10	CAF-9.
Assistant Chief, Files Annex Section.....	do.....	CAF-4	CAF-3.
Chief, Files Annex Section.....	do.....	CAF-5	CAF-4.
Nurse in charge.....	Personnel.....	SP-6	SP-5.
Nurse.....	do.....	SP-5	SP-4.
Stenographer.....	do.....	CAF-3	CAF-2.
Secretary to administrative assistant.....	Board of Veterans Appeals.....	CAF-5	CAF-4.
Statistical clerk.....	do.....	CAF-3	CAF-2.
Assistant legislative counsel.....	Solicitor.....	P&S-6	P&S-5.
Research assistant, Guardianship.....	do.....	CAF-6	CAF-5.
Clerk-correspondence reviewer.....	do.....	CAF-6	CAF-5.
Supervisor, Legislative Records and Research.....	do.....	CAF-9	CAF-8.
Assistant Supervisor, Legislative Records and Research.....	do.....	CAF-7	CAF-6.

Mrs. ROGERS. I think Civil Service maintains that you do not always recommend the higher grade available.

General HINES. Well, there is the evidence.

Now, as I understand, the Legion is on record—

Mrs. ROGERS (interposing). At this present time?

General HINES. I have not noticed a resolution recently, but I know at several times the rehabilitation committee of the Legion has recommended it. I would not be positive about the other two, but I feel confident that the service organizations will recommend to this committee whatever will maintain our hospitals for the care of both service and non-service-connected cases.

Mrs. ROGERS. There is probably an honest difference of opinion as to the best way of doing it, General Hines.

General HINES. Yes.

Now Mr. Chairman, as I have stated, I have completed what general statement I desired to make, and I would be glad to answer any questions for any member of the committee.

The CHAIRMAN. General, I want to ask you a couple of questions. You spoke this morning of two hospitals which you thought were inappropriately located. One of them is the one in New Mexico and the other one is at Dawson Springs, Ky.; is that right?

General HINES. Yes; I used those examples. There are some others that were either located or were building when I took over the work of the Veterans' Administration that I think, if I had to do it over, I would not put in the same place. But we have maintained them. You will find some tuberculosis patients who feel that Fort Bayard and Whipple Barracks are the best place to go to get cured.

The CHAIRMAN. Well is Fort Bayard a tubercular hospital?

General HINES. Yes.

The CHAIRMAN. And Dawson Springs, Ky.?

General HINES. That is also tubercular.

The CHAIRMAN. Those tuberculars, as a rule, remain in hospital, do they not, longer than other patients?

General HINES. They do remain or should remain, but we have had difficulty, as has been brought out, in getting World War II men to stay in those hospitals, and probably some legislation may be needed. This committee is familiar with the fact that if a veteran, a single veteran, goes into our hospital, and he is drawing more than \$20 in compensation or pension, it is reduced to \$20.

During the study of the economies that could be made, that was one of the provisions that was put in, but at that time we were doing what we should not have done, by a man who is rated 10 percent going into a hospital and having his rating increased to 80 percent; therefore we were actually paying him to stay in the hospital.

Now the contention has been made, in connection with the treatment of tubercular patients, that some of those men leave the hospitals before they should because their compensation or pension is cut. That only occurs in the case of the single man, because the married man does not have his compensation or pension reduced when he goes into a hospital.

Various plans have been proposed. One is to impound the payment. Not cut it, but to give him what he needs while he is in the hospital; and others have proposed some way of rewarding him for staying in.

From the study I have been able to make, and from all I have read of the various reports, it would seem to me to be an educational program more than anything else. Some way should be found, if it can safely be done, in which these young men, who have not been home, and who go directly from an Army hospital to our hospital, for them to be given a trial visit as soon as it can safely be done. Because I

am quite sure that you are not going to be able to keep the younger veteran as well as you are the man who is advanced in age and who has been in and out of the hospital and has reached the point where he feels and knows that unless he stays there the chances of him recovering are very remote.

The younger veteran does not realize that. He is impatient. He wants to get home. He wants to see his friends. So we have had difficulty in keeping those men long enough in tubercular hospitals.

Public health will have to assist, not only in the educational program but also in the protection of public health in a given community. Most States and most cities have certain regulations where a man with active tuberculosis is not permitted to visit with people and expose other people to it. But those laws are like some of that character which are very hard to enforce and, in fact, are practically non-enforceable.

I believe that a tubercular patient should be educated, as we are trying to do. We have issued many bulletins on it. The public should assist. His family should be instructed as to the danger of infection to the family, and in the location of tubercular hospitals I believe that we shall have to avoid putting them in remote places.

The CHAIRMAN. Now General, I think our sanatorium is considered one of the best in the United States, and my recollection is that their main treatment is the rest cure. They take them from a small community, bring them out there, put them to bed, and give them the rest cure. It just occurred to me that it may be partly because of that idea that these hospitals are so located.

General HINES. Yes, and some of the patients stay there, and stay there a long time, but the majority will only stay a certain time; and it is not convenient for members of the family to come there, where some precautions may be taken.

When a man leaves the hospital with active tuberculosis, he becomes a real menace, not only to his family but to the community. But you have the same problem in civilian life. You have exactly that.

I feel that 90 percent of it is education of the veteran and the public and particularly of his family.

The CHAIRMAN. Do you know anything, General, about this treatment for leprosy which they are now giving?

General HINES. No, I know very little about it, except that there is some hope that penicillin will give some relief and may stop the progress of the disease. But I do not know enough about it to tell the committee. I can get you information on it, if you wish.

I hope to see a great advance made in the use of certain drugs which have been developing during this war; penicillin, the sulfa drugs, and so on, which undoubtedly will have a far-reaching effect upon anything that flows from the blood stream.

Mrs. ROGERS. Did you know that a very distinguished general spent a year at Fort Bayard when it was an Army hospital because he had a touch of tuberculosis?

General HINES. Well, I know General Pershing used to go frequently to Tucson. We have an excellent hospital at Tucson. We also have a certain number of beds at the hospital at Whipple Barracks, Ariz. I do believe, however, that the medical profession has reached the conclusion that if the tubercular patient, no matter where he is located, will follow the rest cure, obtains a proper cure and good air, and so on, that he will get well just about as soon in one place as in another.



Mrs. ROGERS. General Hines, do you not feel that it is very unfair to cut the amputees and spinal-cord cases, if they happen to be single men and go into our hospitals?

General HINES. I feel we will have to treat them all alike.

Mrs. ROGERS. Do you not think it would be better to change that?

General HINES. I have been debating in my own mind what we really should do with that problem.

Mrs. ROGERS. Those men need to save their money for the future.

General HINES. But I do know one thing, certainly; we should not go back to what we had before, and that is put the incentive on the patient staying in the hospital longer than it is necessary to get well.

I recommended—and the provision went through—to pay full compensation in the case of the man with the dependents. I can see that that creates an inequality in the minds of the veterans, and I am frank to say that I believe we will have to make some adjustment. We did make a slight adjustment by boosting it up \$5 a month, but that does not correct what happens in the case of a man, for instance, who comes out of an Army hospital; as long as he is there, he is generally on active duty; he may draw \$50 a month. Then he goes into a Veterans' hospital and draws \$20, and he immediately thinks he is being penalized.

Mrs. ROGERS. And it takes him a long time to get adjusted.

General HINES. We have got to overcome that, because it affects his treatment. In other words, it affects his ability to get well.

Mrs. ROGERS. I think our rate of pay for the double amputees is low. I know I have talked that over with you, and I introduced a bill to correct that situation.

General HINES. That, of course, should be adjusted, because we are getting a greater variety of types of amputees, different combinations of legs and arms, and together with the loss of an eye, and so on. Those rates should be increased.

Mrs. ROGERS. Double amputations should get at least \$200, even if it is at the ankles.

Mr. PICKETT. General, in connection with that, a number of those with whom I have discussed the matter take the position that where they have lost both lower limbs, above the knee, draw no more compensation than a man who has lost 10 toes: is that correct?

General HINES. There is a little difference. We have recently gone over the whole thing and have a recommendation to make. Odom, has that come out?

Mr. ODOM. Yes, there has been a bill introduced by the chairman, and by Mrs. Rogers, which would—

General HINES. Do you have the details of it?

Mr. ODOM. It is a rather complicated matter, but it would take care of that situation. As a matter of fact, under the rating schedule now, the statement just made is not accurate in all cases. They do give a percentage in the rating schedule for amputations above the knee and below.

Mr. PICKETT. The boys are under the impression that they do not draw any more.

General HINES. I am sure of that, because I talked to some not long ago, and I was very much chagrined to have them feel that a man who had practically lost both his legs, in the upper thigh, was only going to get the same as a man who had lost his feet. Well, of course, our rating schedule has already been modified, but I think the

bill which has been introduced here to increase those rates substantially and to vary them as to where the amputation takes place will more than satisfy them, judging from what they told me when I told them what we proposed to do.

The CHAIRMAN. Mr. Carnahan, do you have any questions?

Mr. CARNAHAN. General, is it estimated that there may be a considerable increase in so-called tropical diseases among our civilian population following the war?

General HINES. I do not know whether that will develop or not. Of course, you do know that we are getting a large number of tropical disease cases coming back. Now how successful the Army and the Veterans' Administration will be in limiting them to those that have them now, will depend on how good treatment we can give.

We anticipate that there will be so many of those, and some of them rather rare and unknown to us before, that we contemplate having a center near Tulane University, or in that neighborhood, where we can take up the study of tropical diseases.

Mr. CARNAHAN. Might that not make it necessary to hospitalize the non-service-connected cases?

General HINES. Oh, I will frankly say to the committee that any attempt to limit the use of our hospitals to service-connected cases will meet with opposition, but the argument presented by Congressman Scrivner, that there is no good reason, certainly, to take more patients in than we can properly handle, is the answer to it. The thing that bothers me, and bothers all of us, is what is going to happen to those men if we do not take them in.

Mr. CARNAHAN. There is a scarcity of doctors and hospitals among the civilian population also.

General HINES. Very much. I think, as a matter of fact, we may be better off than many of them, particularly State and county hospitals. I heard, only recently, that a hospital up in Massachusetts practically had to close down, or limit the number they could take in because of the shortage of help, just as we are experiencing.

Mr. CARNAHAN. And for a lot of non-service-connected cases, unless they get their hospitalization from the veterans' services, it means they will not get it at all.

General HINES. That is correct.

Mr. DOMENGEAUX. General, when you mention this medical set-up for tropical diseases, which you are now contemplating in New Orleans, near the Tulane University, which I think is an excellent site, is that hospital in addition to the—

General HINES. It would really be some kind of a clinic connected up with Tulane University.

Mr. DOMENGEAUX. That is in addition to—

General HINES (interposing). To the other hospitals.

Mr. DOMENGEAUX. To those scheduled under the present recommendation?

General HINES. That is right.

Mr. CARNAHAN. Are any of the leprosy cases hospitalized outside the continental United States?

General HINES. All the leprosy cases we have anything to do with go to the hospital in Louisiana.

The CHAIRMAN. You also have a leprosy hospital in the Hawaiian Islands, do you not?

General HINES. Yes, but that is operated by, I think, a civilian unit out there.

The CHAIRMAN. Mr. Scrivner, do you have any further questions?

Mr. SCRIVNER. The General has been very patient, Mr. Chairman. I want to make one observation and ask two questions and then I am through. The observation is that this discussion relating to non-service-connected cases, of course, relates primarily to our present emergency, and of course would except from it what we would normally call our institutionalized cases, which would properly include those with diseases such as those mentioned by Mr. Carnahan, the tropical diseases, because that is a matter that is a menace to the community.

General HINES. Also tuberculosis.

Mr. SCRIVNER. That is right, mental patients, tuberculosis patients, we consider them as institutionalized, and of course they are automatically excepted from our discussion.

General HINES. Yes.

Mr. SCRIVNER. Now I have read this H. R. 3310 a couple of times, and I was surprised to receive a letter, yesterday, stating that in there, some place, was a proposal to hospitalize the families and dependents of all of our service men. Is there anything like that in the bill, or contemplated?

General HINES. Not contemplated. The only provision there would be to take care of hospital personnel that are employed there, at the hospital itself. It would not take in the dependents of veterans generally.

Mr. SCRIVNER. The reason I ask is because I received that letter.

General HINES. I have had a similar letter. I do not know who wrote it to me, but it stated that we were going to hospitalize the families of the veterans.

Mr. SCRIVNER. Well of course that would take in almost half of the population, I would imagine.

General HINES. That would be impossible.

Mr. SCRIVNER. Now the last question I have is that in all of this discussion, both by you and the members of your staff, it has been recognized, and has been stated as a fact, that the obtaining of our professional personnel under civil service just has not worked. And I was just wondering how long that fact had been recognized.

General HINES. I doubt if we recognized it until we got into this war. Then we commenced to lose our doctors, and tried to replace them, and we found that those that remained available on the civil service lists were not equal to those we had lost.

Mr. SCRIVNER. So prior to the time the war came along, then, you were not experiencing any difficulty in getting the doctors you wanted under civil service?

General HINES. Except I do not feel that the standard pay, under civil service, is high enough to attract the best doctors.

The CHAIRMAN. General, you spoke of tropical diseases; do you have any trouble with thyroid cases?

General HINES. We have a number of those cases, but I think that generally the treatment they have for them, and then finally surgery, is about the only cure.

The CHAIRMAN. You do not have any figures as to the number of those cases?



General HINES. I do not have them at hand, but I can furnish them for you.

The CHAIRMAN. Would you submit them for the record?

General HINES. I will be glad to. We have the entire group of that type of disability, but I know we have definite information on the number of thyroid cases and the treatment and what has happened.

(The information referred to above is as follows:)

*Analysis of World War I veterans in receipt of compensation or pension for thyroid disabilities over a period of 5 years*

	Total cases on rolls for all disabilities	Total		Thyroid disabilities (number of cases)		
		Number	Percent of total cases	Goiter, benign	Hyperthyroidism	Hypothyroidism
Sept. 30, 1940:						
Service-connected.....	349,815	2,622	0.7	32	2,478	112
Non-service-connected.....	63,864	177	.3		167	10
Total.....	413,679	2,799	.7	32	2,645	122
Sept. 30, 1941:						
Service-connected.....	350,035	2,571	.7	30	2,425	116
Non-service-connected.....	75,106	198	.3		183	15
Total.....	425,141	2,769	.7	30	2,608	131
Sept. 30, 1942:						
Service-connected.....	346,454	2,466	.7	26	2,329	111
Non-service-connected.....	83,667	201	.2		184	17
Total.....	430,121	2,667	.6	26	2,513	128
Sept. 30, 1943:						
Service-connected.....	340,099	2,391	.7	24	2,264	103
Non-service-connected.....	85,552	195	.2		180	15
Total.....	425,651	2,586	.6	24	2,444	118
Oct. 31, 1944:						
Service-connected.....	334,250	2,338	.7	24	2,210	104
Non-service-connected.....	87,871	203	.2		185	18
Total.....	422,121	2,541	.6	24	2,395	122

Source: Veterans' Administration budget and statistics, July 5, 1945.

*Analysis of World War II veterans in receipt of service-connected pension for thyroid disabilities on June 30, 1944 and Mar. 31, 1945*

	Total cases on rolls for all disabilities	Total		Thyroid disabilities (number of cases)		
		Number	Percent of total cases	Goiter, benign	Hyperthyroidism	Hypothyroidism
June 30, 1944.....	208,516	188	.1		133	55
March 31, 1945.....	433,849	411	.1	7	281	123

Source: Veterans' Administration budget and statistics, July 5, 1945.

The CHAIRMAN. I saw, in 1931, that it was reported that more people died, in the State of Illinois, from thyroid trouble, that year, than died in Mississippi from thyroid trouble, malaria, and typhoid, all three combined.



## COMBINED FACILITIES

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General HINES. Well there are certain sections of the country apparently where the thyroid gland develops, either through what they drink, or what they eat. It develops more rapidly than it does in other sections.

The CHAIRMAN. That is because of the lack of iodine in their food.

General HINES. Iodine is, of course, one of the forms of treatment for thyroid.

The CHAIRMAN. Along the Gulf coast, and in Florida, and also in southern Texas, it is the rarest thing in the world to find a case of thyroid trouble.

General HINES. I know there are certain sections where the soil and water there is more iodine, and of course from the soil and water it goes into vegetables.

The CHAIRMAN. Yes; and of course the rain in that area all comes from the Gulf, from the sea, and it contains iodine. When you get farther north, probably to latitude 35, the rainfall from there north is relay rain, rain that falls from the Gulf and then evaporates and is carried on. And the further you get from the Gulf, or from the ocean, the less iodine you find in the soil.

General HINES. Yes.

The CHAIRMAN. And the more thyroid trouble you encounter.

General HINES. Yes.

Mr. CHAIRMAN. This idea of putting iodine in the salt apparently has not helped the situation much.

General HINES. Well I could not say whether it has or has not—Congressman; I know that is one of the forms of treatment, and in some cases it is very successful. It avoids the operation.

Mr. McQUEEN. I have some matters to place in the record before you adjourn, Mr. Chairman.

The CHAIRMAN. Proceed.

Mr. McQUEEN. I wish to introduce in the record this chart of the opening and closing of Veterans' Administration facilities, hospitals, homes, and combined facilities, from 1919 down to 1945, which General Hines testified from this morning.

The CHAIRMAN. Without objection, it is so ordered.

Mr. McQUEEN. I also wish to introduce a statement Mrs. Rogers requested, as to women patients, as of May 31, 1945.

The CHAIRMAN. Without objection.

Mr. McQUEEN. And a statement of Dr. Jerome R. Head, of the Harvard Medical School, which is a dissertation on tuberculosis. General Hines testified from it this morning.

The CHAIRMAN. Without objection.

Mr. McQUEEN. Now when I came down here in the early part of May, I wrote letters to the different veterans' organizations and yesterday I received a letter in answer to my request from the United Spanish War Veterans to be here to testify, in which their national commander states that, so far as he has been able to find out, and with some supporting data, their class of veterans has been very well treated throughout all the hospitals and he did not feel it was necessary to take up the time of the committee, but I would like to put his letter in the record.

The CHAIRMAN. Without objection.

(The information referred to is as follows:)

MARCH 15, 1945

Statement by Jerome R. Head, M. D. (Harvard Medical School, 1922; licensed to practice 1926; specialist in tuberculosis; fellow of the American Medical Association; fellow of American College of Chest Physicians; member American Association for Thoracic Surgery; associate professor of surgery, Northwestern University; medical director, Edward Sanatorium, Naperville, Ill.; consultant in thoracic surgery, Veterans' Administration facility, Hines, Ill.)

Mr. Maisel's criticisms of the medical service of the United States Veterans' Administration is unwarranted and untrue. To accomplish a worthy end he has stooped to an unworthy method and has indulged in a form of journalism which would shame an honest man or an honest editor—a form of journalism which by its obvious, if not willful, falsehoods puts in jeopardy every conscientious man and every reputable institution.

To high-light the need for certain changes which present conditions have suddenly made necessary he has willfully and, either ignorantly or maliciously, attacked a good service and a group of men who are capable, honest, and hard-working. I shall attempt to show that he is either ignorant or dishonest.

To anyone familiar with this type of journalism and at the same time knowing something of medicine and of human nature, it is obvious that Mr. Maisel made his inspection of the Veterans' Administration facilities at the instigation of some one else, and not with the idea of reporting things as they are, but rather with the premeditated purpose of finding fault. It is as if a malicious gossip had come into your home or my home and then broadcast the astounding information that there were flyspecks on the front window, children's rubbers and overcoats scattered disgustingly about the front hall, broken toys littering the living room, and a filthy cobweb on the dining-room chandelier. It is a tribute to the Veterans' Administration that a man of Mr. Maisel's character and intent had to base his indictment on such questionable motes of evidence and on a misleading interpretation of statistics.

For the past 14 years I have served as a consultant in tuberculosis, diseases of the chest, and thoracic surgery at Edward Hines Jr. Hospital, of the Veterans' Administration. During this same period I have been at one time or another consultant in the same specialties to the Chicago Municipal Tuberculosis Sanatorium, the Cook County Hospital, and the Oak Forest Tuberculosis Hospital. Throughout this period I have engaged in private practice in Chicago and have been medical director of a private tuberculosis sanatorium. At no time have I been at all dependent upon my salary from the Veterans' Administration, and have continued in my position only because I was deeply interested in the work.

I mention these things merely to show that I am familiar with the medical service of the Veterans' Administration; am especially cognizant of the treatment of tuberculosis both there and in other public and private institutions, and that I am now, and have been heretofore, in an independent position, with no selfish restraints upon my freedom to judge, speak, and criticize. While I can testify from intimate knowledge only of the facility with which I am connected, in the field of tuberculosis, I am familiar with the work which has been done by the central office to keep the treatment abreast of the new developments in the field. I can truthfully say that this has been intelligent and timely. I can also truthfully say that every institution with which I have been connected, and every physician whom I know, including myself, could be made the subject of such an indictment as this that Mr. Maisel has been induced to make against the Veterans' Administration.

This is not because these institutions and physicians are bad (many of them have outstanding reputations), but because in every institution there are disgruntled patients who believe that their failure to improve is due to neglect or their lack of appetite is due to poor or cold food. In every institution also, human nature being what it is, there are occasional members of the medical or nursing staff who are not up to standard and do not do their work well, or as directed. Every doctor, regardless of his training and ability occasionally makes mistakes in diagnosis and judgment, and in all fields of medicine, especially in tuberculosis, there are honest differences of opinion between the best physicians.

But let us consider Mr. Maisel's indictments in the order in which he has presented them.

1. He states: "Yet only one patient in six ever leaves these beautiful buildings labeled as cured." To the layman who is not familiar with routine hospital



rating of results this sounds like a serious criticism. Like most of Mr. Maisel's statements it is misleading. Very few patients are ever discharged from any hospital labeled as cured. At Wesley Memorial Hospital in Chicago, one of the most modern institutions in the country, only one in — patients is discharged as cured. No patient with tuberculosis or cancer is ever discharged as cured. Many of the hospitals which Mr. Maisel visited had a high percentage of tuberculosis cases, and the incidence of cancer in men in the 45 to 55 age group (this includes all of the veterans of World War I), is infinitely higher than in the general population. In most diseases the patient can be considered as cured only after he has worked for sometime without a recurrence of symptoms. In cancer and tuberculosis this is anywhere from 5 to 10 years. Furthermore, the Veterans Administration facilities admit chronic degenerative diseases, and in the 45- to 55-year age group all of these are incurable. Heart disease, high blood pressure, kidney disease, diabetes, Buerger's disease, arthritis, mental conditions, and many more are incurable. They can be improved, but the cure is out of the question. One cannot make new or replace organs which have become damaged by the wear of years and the strains of existence. In making this statement Mr. Maisel was either ignorant of general hospital classification of results and of the peculiarities of the age and sex group of the veterans, or he willfully misrepresented the truth.

2. Mr. Maisel says: "Everywhere I have found disgraceful and needless overcrowding."

In every community in the country at the present time, hospitals are overcrowded as evidenced either by beds in halls, porches, or other space ordinarily used for less urgent things, or by long waiting lists of sick patients who have to wait days and weeks for admission. This overcrowding is neither disgraceful nor needless. It is an expression of a laudable effort on the part of the hospital administration to adjust the wartime emergency.

In Edward Hines, Jr., Hospital there is little if any overcrowding. What crowding there is is neither disgraceful nor needless, and certainly does not comprise the patient's basic well-being, or his chances for recovery.

Shortly after the end of the war the many Army hospitals in this country will be rapidly emptied and will become available for use by the Veterans' Administration. For this agency to build many new hospitals now without first making the utmost use of present space, would be wasteful and censorable. It is as if one were to criticize the city of Chicago for the disgraceful shortage of meat and housing.

3. Mr. Maisel says: "I have found doctors so overloaded that they could give the average patient only 7 minutes' attention a week."

The average patient needs no more than 1 minute of immediate personal attention a day. After the history and physical examination have been completed, the diagnoses established, and the treatment started, the doctor can check the patient's condition and progress in a minute. Only when the course is not satisfactory is more time required. In this connection one should remember that no doctor is ever away from his patients. They are continually on his mind—while he is eating his dinner, while he is resting at home, and even while he is sleeping. Many of the most important decisions concerning diagnoses and treatment are made almost subconsciously in these spare hours. In this statement Mr. Maisel is either ignorant of the nature of medical practice, or is being willfully misleading. The 7 minutes which Mr. Maisel mentions do not include the all-important time in conferences and consultations which do not take place in the patient's room.

4. Mr. Maisel says: "I have found some men—a minority—devoted to their patients, etc.; well-run hospital; cynical men, who joked about their patients' miseries; incompetent men, who rejected offhand every modern advance in medicine."

A statement that human nature is this bad, or that the Veterans' administration has become a repository for monsters and fiends in the guise of physicians should stretch the credulity of the least informed. I have worked with these men for the last many years. The great majority of them are capable, conscientious and sympathetic. Many of them are as capable physicians or surgeons as can be found in the world. As a group they are average physicians and I have still to see one who is grossly incompetent, a cynical fiend, or a cold-blooded monster. To the layman, physicians may seem to be callous. It is necessary protection. Any physician who entered emotionally into the pains and miseries of his patients could not stand the strain and, what is more, could not be a good physician.



A degree of objectivity is essential to the physician's survival and to the balance of his judgment. But beneath this exterior the physician is still a man, and is usually a good one, sympathetic, compassionate, and working to the best of his ability to cure his patients and alleviate their sufferings. I have never seen a physician who willfully denied a patient needed surgery, or refused him treatment which might have cured.

The remainder of Mr. Maisel's article is devoted to the subject of tuberculosis. He opens his indictment by citing two cases. Let us examine the evidence on which he has based his conclusion that Harold Schweibert, and Jimmie Collier were mistreated. It may be that they were, and it may be that the physicians concerned were neither negligent or incompetent. He presents no evidence that definitely suggests it. Harold Schweibert gained the impression that he was not being well treated and wrote a complaining letter to Dr. Brueckner requesting admission to the sanatorium at Lima, Ohio. There are patients in every sanatorium who attribute their failure to improve to lack of competent care. I imagine there have been some in Dr. Brueckner's sanatorium, there have been in mine, and I would sincerely dislike being indicted, tried and convicted solely on the testimony of such a patient. Yet Dr. Brueckner, without investigation, assumed that the patient's appraisal of his own needs was correct. If Dr. Brueckner were older and more experienced, he would have known that a layman's opinion of his own condition and his own needs for treatments, or his reports concerning any medical question, are usually incorrect. He would have hesitated to accept them at face value.

The same can be said for Dr. Dublin.

Later Harold Schweibert died. This is the final fate of many patients who have tuberculosis. In itself, it is no criticism of the physician. Dr. Brueckner then wrote to Dr. Dublin (and there is no record that he knew the cause of death), stating that Harold Schweibert died of apparently cardiac failure and cardiac embarrassment probably because of severe mediastinal shift caused by effusion. This is all inference on the part of Dr. Brueckner, who started by assuming that the patient's complaints were true and ended by making a diagnosis in absentia. One will note the words "apparently" and "probably" in his last letter. Dr. Dublin apparently turned over the correspondence to Mr. Maisel.

Now let us see what Mr. Maisel does. He writes "In simple English, Harold Schweibert died of heart failure because the wall that separated the right and left lung was forced against his heart by fluid that gathered in his lung cavities—the fluid Schweibert begged to have removed." All doubt has now been removed; there are no "apparently" or "probably." Mr. Maisel states as a certain fact that death was from cardiac failure and intrapleural pressure. The process has skipped lightly from hearsay to inference, to fact. The childishness of this logic is laughable. It puts Dr. Dublin, Dr. Brueckner, and Mr. Maisel in the inevitable position either of being so ignorant of elementary logic and the rules of evidence that they are completely untrustworthy, or of being intentionally dishonest.

Let us examine the case of Jimmie Collier. In Mr. Maisel's presentation of this case there is the same willingness to accept the patient's story, and the hearsay evidence of nurses. The story as Mr. Maisel presents it is that the patient, who had been on strict bed rest, was sent unattended from Castle Point, N. Y., to the Bronx Facility, and that there he was put on meal and bathroom privileges and there it was decided that the operation for which he had been transferred was not indicated because of disease in the opposite lung. Mr. Maisel assumes on the hearsay evidence of nurses that this occurred as a result of his transfer.

The Veterans' Administration is extremely careful about the transportation of sick patients. When it is necessary for a man to be transferred from one facility to another, or from a facility to his home, his case is carefully considered, and in all instances where it is deemed at all necessary, an attendant is supplied and sleeping accommodations obtained. In each case, a form must be filled out stating whether or not an attendant is necessary. One can be sure that his matter was considered in this case.

Furthermore, patients with tuberculosis, even those on complete bed rest, are not usually acutely ill. Most of them appear and feel healthier than you and I, and most can stand exercise without being made worse. In all sanatoria such patients are allowed to go home over holidays. Castle Point is almost within commuting distance of the Bronx. It should be added that once operation has been decided upon, complete bed rest can reasonably be abandoned. Some surgeons purposely put their patients on exercise before operation, feeling that it strengthens them to stand the procedure. As to the final decision that the operation was not

indicated, this may have been the result of a difference of opinion between the chest surgical board at Castle Point and that at the Bronx. Such differences are common and understandable. Or the decision may have been altered because of a spread of the disease to the opposite lung. Such spreads are common. If such a spread occurred in this case, it is by no means certain that it was caused by the trip. Spreads frequently occur while the patient is on complete bed rest. This is so common that most surgeons demand a new X-ray the day of operation. On the basis of these last-minute examinations, operations are frequently canceled, even after the patient has been put on the operating table.

Jimmie Collier stated to Mr. Maisel that the authorities at the Bronx Facility had no knowledge of him. This is either untrue or was the result of an unusual slip up in routine. In the Veterans' Administration, as a whole, very careful arrangements have been made for the transfer of patients for chest surgery. The case is first brought before the chest surgical board at his home facility. If surgery is deemed necessary, a detailed abstract of his record and all of his X-rays are sent to the chest surgical center. There they are examined and considered by the chest surgical board. If this board of specialists considers that surgery is necessary, transfer is advised. I feel sure that this procedure was carried out in the case of Jimmie Collier. If it was not, it was an unusual slip in routine procedure.

In this indictment it seems that Mr. Maisel was either illogical or deliberately dishonest.

We come now to Mr. Maisel's consideration of the statistics. That statistics can be made to lie is a truism. I would not mention it did I not suspect that Mr. Maisel would be glad to encourage them in this propensity. He states that the 1943 annual report of the Veterans' Administration shows that only 2.3 percent of 10,000 patients treated were discharged as arrested. In the first place I will say that from the private sanatorium of which I am medical director no patient is ever considered "arrested" at discharge. In spite of this, approximately 70 percent of all cases are well and working when checked on from 3 to 7 years later. The patients are discharged to home and ambulatory treatment as soon as it is apparent that on this regime they will proceed to an arrested state. On the basis of discharge statistics, this institution is worse than the New York State sanatoria cited by Mr. Maisel, and worse even than the Veterans' Bureau. On the 3- to 7-year statistics (the only ones that count in tuberculosis), it is better. Statistics can be made to lie. Mr. Maisel probably knows little of the intricacies of statistics, but Dr. Dublin, who probably colluded in the preparation of this article, certainly should. It is well known that conclusions drawn from a comparison of different sets of statistics can be reliable only if the statistics are identical in every way and are compiled from identical material. In 1943 there were very few veterans of World War II in veterans' hospitals. The preponderance of patients were veterans of World War I. This means that they were nearly all males and nearly all 45 to 55 years old. They comprised a very definite sex and age group, which can in no way be compared with the group represented in other sanatoria. — percent of them were colored patients and a fair percentage of Mexicans, Filipinos, and Indians, races which are particularly susceptible to tuberculosis and in which the death rate, in spite of the best treatment, is always high and the recovery rate always low.

The majority of cases of tuberculosis in men in the 45-to-55-year age group are of the chronic bilateral hematogenous type. This type, extremely rare in younger patients, is characterized by chronicity, by extrapulmonary tuberculous complications and by its resistance to treatment. Because it is bilateral, very few of the patients can be treated by surgery, and because it is chronic, collapse by pneumothorax is usually unsatisfactory. It is a distinct and peculiar type of tuberculosis, which is in no way comparable to the acute bronchiogenic forms which occur in younger people and make up the majority of cases in most sanatoria.

There are many other factors which make tuberculosis in this sex and age group different from tuberculosis in general. Men at this age are commencing to show the effects of years and work. Heart disease, high blood pressure, emphysema, renal disease, cancer, silicosis, and alcoholism are all common. Deaths from these and other degenerative diseases, are frequent, and all of these diseases tend to make recovery from tuberculosis improbable or impossible, and to contraindicate surgery or collapse.

Absolutely no valid conclusions can be drawn from a comparison of tuberculosis in this sex and age group with tuberculosis as a whole. Mr. Maisel could probably have obtained these facts from Dr. Dublin who, being a life-insurance physician, should, if he is worthy of the name, be well aware of the vagaries of statistics.



One could go on in this way, taking up one by one of the criticisms that Mr. Maisel has made. There is not one which is just or wholly free from the suggestion of ignorance or dishonesty. But having gone this far, one feels as he might after a malodorous woodland encounter—that he had better bury his clothes, deodorize and go on to more fragrant pursuits.

For the past 20 years I have been intimately associated with the developments in the treatment of tuberculosis, and for the past 18 years have been familiar with this work in the Veterans' Administration. During this time tremendous changes have taken place. New methods of treatment have been developed, tried, and adopted, and the whole subject of collapse of the lung has come to occupy an increasingly important place. Everywhere this has come about by a process of evolution, in which every change has had to be forced against the opposition of honest but reactionary physicians. As late as the early 1930's surgeons in many public and private institutions could secure permission to operate upon patients only when the medical men had given up after years of ineffectual treatment and delay. This was true throughout the world. In 1934 in one Veterans' Administration facility it was necessary to have the chief of the tuberculosis service transferred to other work because he was sincerely opposed to the use of any surgery on tuberculous veterans. As late as his retirement in 1938 the professor of tuberculosis in Northwestern University Medical School of Chicago was definitely opposed to surgery in tuberculosis, and the author of one of the principle textbooks on tuberculosis, a New York professor, expressed the same views. In spite of such stubborn, but truly salutary opposition, the use of the procedures spread. It is significant that one of their most successful advocates was Dr. Philip Matz, who was the head of the research subdivision of the medical and hospital service in the central office of the Veterans' Administration in Washington. From the time that he took over the work until his death, he and Dr. David C. Farnsworth, the head of the tuberculosis division, worked intelligently and successfully to see that collapse therapy was used in every facility to the limits of its possibilities. Directives were sent out from the central office. Collapse therapy boards were established to consider every patient as to the possibility of the use of this form of therapy, chest surgery centers were organized, reactionary physicians were weeded out, and every facility had to send in reports on the percentage of patients given this treatment. Dr. Matz made regular personal visits to each facility and participated in the conferences of the boards. Since his death the work has been ably carried on by Dr. Henry Rolfe Brown, Dr. Smith J. Mann, and at present by Dr. Roy A. Wolford, assistant medical director in charge of tubercular service and hospitals.

That the percentage of cases treated by collapse therapy in the Veterans' Administration facilities was not as high as in other institutions is attributable to the nature of the disease in this particular sex and age group. That this is so is borne out by the fact that prior to the influx of the World War II veterans only two mornings a week were set aside for chest surgery at Edward Hines, Jr., Hospital. During the past year and one-half, it has become necessary to double the number of surgeons and assistants, and to operate five days a week. This has come about not because of any change in policy, but simply from a change in the ages of the veterans.

Mr. Maisel might well have looked into this matter and considered current figures—not those of 1943.

I have said that Mr. Maisel and his collaborators have used despicable methods to accomplish a worthy end. Everything is not as it should be in the medical service of the Veterans' Administration. Because it does not merit the extreme attack made by Mr. Maisel, does not mean that it is above criticism or beyond improvement. The central office, has, in my experience, always welcomed intelligent suggestions and has always been ready to act upon them. Recently a number of the consultants associated with the service have felt that many basic changes should be made to fit it for the increasing burdens which it will have to bear and the increasingly important place which it will come to occupy in American medicine as a whole. These matters were discussed at the time of the May 1944 meeting of the American Association for Thoracic Surgery, and as a result of these discussions, recommendations were drawn up (long before the appearance of Mr. Maisel's article) for circulation among the consultants and for eventual forwarding to the central office, to the American Legion, and to the appropriate committees of Congress. It is surprising that the recommendations coincide so closely with those made in Mr. Maisel's article. This suggests that the recommendations came from one source and the "muckraking" followed from another source. The report for the consultants is as follows:



Those of us who for many years have been medical consultants in the Veterans' Administration have developed a personal interest in the service. This interest has led naturally to a desire to contribute to its improvement. At the present time the administration is in the early stages of an enormous expansion—an expansion which will multiply manifold the number of veterans eligible for care and consequently also the number of facilities and the number of administrators, doctors and nurses. Realizing that for many years it will play an increasingly important place in the medical work in this country, and knowing that various changes will have to be made to meet these new responsibilities, it has seemed desirable that we make what suggestions we can for the improvement and expansion of the service. We feel that we are in a position to do this effectively, in that we are familiar with the organization as it has been functioning over the past years, and with objectivity, because we are far more interested in the work than we are dependent upon it.

It is self-evident that the purpose of the medical service of the Veterans' Administration is to supply the best possible medical care to the veterans. It is also self-evident that this is almost wholly dependent upon the ability and training of the individual physicians doing the work. The service will attract and retain the ablest physicians only if it offers them careers which are comparable in remuneration and opportunity to those which they can attain elsewhere. Heretofore, the Administration has not offered good careers to the physicians whom it employs. The pay has afforded barely a subsistence to men with families, and retirement at 70 has been on a pension of no more than \$150 a month. It is common for men on being retired to have to seek other employment in order to maintain themselves for the rest of their lives.

The difference between subsistence pay and adequate pay is not great. The certainty of advancing to an adequate income and the possibility through special ability of attaining a good one, together with the security afforded by a good pension and the freedom from the worries and hardships of private practice, would surely attract to the service many of the best graduates of the medical schools.

It would do this only if they felt that the nature of the work would give them an opportunity of expressing themselves and realizing their ambitions in the medical field. Most physicians are deeply interested in their work and the better ones, especially in their earlier years, are more interested in advancing the science and perfecting themselves in its practice than in acquiring money.

The administration should afford time and facilities for clinical and laboratory investigation, and should encourage it by offering advancement on the basis of contributions in these fields. It should do this, not only to attract good men to the service, but to improve the service and to fulfill its responsibilities to medicine. Advance in medicine is largely dependent upon the investigation work of practicing physicians and especially upon those who have access to copious material. For the Veterans' Bureau to take, as it will, so many physicians and so much material and make no effort to encourage scientific work, is not conducive to good practice in the service and is to neglect its responsibility to the science of medicine.

Young men entering the service should be so rotated on services that they will get a broad general training in medicine and eventually a thorough training in a specialty. They should be given time for postgraduate courses, either at the larger facilities or at outside clinics. They should be given time to attend medical meetings and conventions, and encouraged to contribute to the programs. Arrangements should be made whereby this training received in the bureau will be accepted as credit toward the diplomas of the various accrediting boards.

It is probable that many of the younger men would enter the service solely for this training and would eventually leave and go into other work. This should be expected, and even encouraged to the extent that special arrangements should be made for training men who do not intend to remain in the service. If the permanent service is made attractive, there will be competition for the permanent positions, and the service will eventually keep the best men it has trained and, at the same time, serve a valuable function in training men for the country at large.

These men in training could be used to fill one of the great needs of the service as it now conducted, namely, that of resident physicians. Today, even in the larger facilities which contain as many as 2,000 beds, only 3 physicians are on service between 4:30 p. m. and 8:30 a. m. In most instances, these men are not familiar with the conditions of the acutely ill patients for whom they are responsible. It is not good practice for a neurologist or dermatologist to have to prescribe for acutely ill surgical patients whom he has never seen before.

The facilities should have adequate libraries and library services, so that all of the physicians could have immediate access to current journals and texts, and

feasible access to all medical literature. These libraries should be kept open at night as well as throughout the day.

Complete diagnosis files should be kept. There should be an adequate follow-up system, and statisticians should be employed to determine the end result of treatment of the various diseases.

At the present time the cost of medical care in veterans' hospitals greatly exceeds that in private practice. This is caused by the transportation of patients to and from facilities and by unnecessarily long hospitalization. If a department were established for expediting the passage of patients through the hospitals, it is probable that the number of buildings, beds, nurses, and attendants necessary to care for eligible veterans over the coming years could be cut in half. It could be further greatly reduced if care of non-service-connected disabilities were afforded only to those who were truly indigent.

In the case of tuberculosis and probably of some other conditions, the service should be integrated with the various county and state facilities. In the case of tuberculosis it is much better that the patient be cared for close to his home, where ambulatory treatments and the necessary frequent check-ups can be taken care of by the physician who has treated him throughout his illness. If the administration is to assume responsibility for the care of tuberculosis, it must make elaborate Nation-wide arrangements for giving pneumothorax to ambulatory patients and for following and checking those in whom the disease has been apparently arrested or arrested. Rather than do this in duplication of the city, county and State services, it would seem preferable for the Veterans' Administration to abandon the treatment of tuberculosis and devote its energies to seeing that city, county, and State facilities are increased sufficiently to provide adequate care for all citizens.

In accordance with the ideas expressed above, the following suggestions are offered for consideration:

1. That rates of pay be increased so that after 15 years' service the minimum salary will be \$8,000 a year, and that the salaries of those, who, through special administrative, clinical or investigative ability, had attained to positions of greater responsibility, should range from \$9,000 to \$12,000 per year. That retirement should be at age 65 on three-quarters pay.

2. That advancement should be in part dependent upon clinical or laboratory investigations and contributions to the literature, and that time and facilities be afforded for this type of work.

3. That in the larger facilities planned rotation of services be outlined for younger men entering the bureau so that they can receive a broad training in general medicine or surgery, and eventually in some specialty, and that this training be of such a nature that it will be accepted by the accrediting boards. That these younger men in training should live in the hospitals as residents. That their appointments should be temporary and their remuneration not more \$1,800 year. That at the end of their period of training the necessary number be chosen for permanent appointments. That men on permanent appointments who have become thoroughly competent in the larger facilities be eventually sent out to fill vacancies or establish services in the smaller facilities from which again they might look forward to being recalled to more responsible positions in the larger units.

That the larger facilities conduct postgraduate courses to which men from the smaller facilities can be sent for short periods of advanced training.

That opportunities be given all men for clinical trips and attendance at medical meetings and conventions.

That medical library services be established or improved so that all physicians can have immediate access to current journals and texts, and feasible access to all medical literature.

That record libraries with librarians and statisticians be established so that maximum use can be made of the clinical material.

That it be part of the function of the younger physicians to work up and publish this material under the direction of the older men.

That a service be established for expediting the passage of patients through hospitals and a social service department for ascertaining the eligibility of those applying for care of non-service-connected disabilities.

It may be objected that these changes are impractical on account of the expense which they would entail. This objection is not valid for the following reasons:



1. The Veterans' Administration cannot be satisfied with less than the best medical care and these changes are essential to the best.

2. The facilities for training competent physicians throughout the country are inadequate for supplying the administration with the necessary number of men. For this reason, the service must meet the responsibility, which is recognized by all civilian medical institutions, of training men for its own staff and for the country at large.

3. Advancement of medical science is a recognized function and responsibility of all medical organizations. It cannot justifiably be ignored by the Veterans' Administration. In addition, the quality of medical care will be better where this work is being carried on and the quality of men attracted to the service will be improved.

4. The increase of expense will be largely compensated for by the fact that much of the work which does not require experience and does not carry responsibility will be done by young and low-salaried resident physicians under the direction of the older men.

It may be objected that research and the training of younger men should not be a function of the Veterans' Administration. This objection is not valid for the following reason:

Research and the training of younger men are important and necessary functions of all good physicians and medical institutions.

In all of this discussion and in all of these recommendations, the basic criticism of the medical service of the Veterans' Administration has been overlooked. No one has asked "Should there be a medical service especially for veterans?" Certainly every veteran, regardless of his ability to pay, should have the best possible medical attention when he is ill. But in this respect, how is the veteran different from the nonveteran? Should not every individual have the same? Would it not be better for the Government, working intelligently with a reorganized and rejuvenated American Medical Association, to devote its energy and money to speeding the improvement of the practice and distribution of medicine throughout the United States, so that no veteran and no individual would have anything but the best? Then there would be no need for a medical service in the Veterans' Administration. The veterans, together with their fellow citizens, could then be treated by physicians of their own choice in their own communities.

To this it will be objected that the questions of rating of disability and of qualifications for pensions could not possibly be handled under these conditions. This is not a valid objection. The life-insurance companies handle these matters without maintaining their own hospitals. Why cannot the Government do the same?

But if the Government enters this intimately into medical practice and distribution throughout the Nation, there is grave danger that it will do it unintelligently by interrupting rather than speeding and aiding an evolution which already is rapidly approaching the desired goal. Many of the shortcomings of the Veterans' Administration as it is today are inseparable from Government medicine where doctors are made subservient to bureaucrats and politicians. What the Army is doing to medical education has recently been told by Dr. Evarts Graham. What the Government might do to medicine, as a whole, by making the profession unattractive and the service impersonal and perfunctory, is not a pleasant consideration. It might end by giving medical service to everyone but good medical service to no one. If the matter were handled intelligently by men wise enough to consider human nature and human incentives, everyone could have the best.

To anyone familiar with the matter, it is obvious that Mr. Maisel's program for change was supplied him by a physician more or less familiar with the workings of the Veterans' Administration, and that his function was to go out and find justification for it. The program, with certain modifications, is excellent. Mr. Maisel's adventure into "muckraking" is despicable and ludicrously inept. In journalism, as in other matters, truth is surely more effective than untruth. A good and restrained criticism could have been presented. Instead, Mr. Maisel has stooped to cast unwarranted opprobrium upon a good service and upon good men. In this connection, Theodore Roosevelt, who coined the term "muckraker," wrote: "I want to let in light and air, but I do not want to let in sewer gas. If a room is fetid and the windows are bolted, I am perfectly contented to knock out the windows; but I would not knock a hole into the drain pipe."



MAY 9, 1945.

Mr. R. MORGAN GALBRETH,  
*Commander in Chief, United Spanish War Veterans, National Headquarters,  
 Washington, D. C.*

DEAR COMMANDER GALBRETH: The investigation of the Veterans' Administration by the Committee of World War veterans, Hon. John E. Rankin, chairman, will very shortly be under way.

You are invited to appear before this committee with any information which you have pertaining to your organization and the care of veterans within your organization, and also any constructive suggestions which you may have for the betterment of service to the veterans as a whole.

I would suggest that you notify the committee at an early date as to the probable time that you may desire to appear.

Cordially yours,

JOE W. MCQUEEN,  
*Counsel, World War Veterans' Investigating Committee.*

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UNITED SPANISH WAR VETERANS,  
 OFFICE OF COMMANDER IN CHIEF,  
 Los Angeles, Calif., June 28, 1945.

Hon. JOHN E. RANKIN,  
*Chairman, House Committee on World War Veterans,  
 Washington, D. C.*

DEAR CONGRESSMAN RANKIN: Through counsel for your committee, Joe W. McQueen, I have been invited to appear before your committee. In answer, let me say as commander in chief of the United Spanish War Veterans that I have not received from any of the 48 departments of our national organization, or from any officer thereof, any complaints as to the mode or manner of the treatment of the Spanish War veterans in any of the hospital units under the Veterans' Administration management.

In conformity to the request of the ODT, my visiting of the different departments has been very limited. But in the hospitals under the Veterans' Administration that I have visited during the last 3 years that I have held a national office in the United Spanish War veterans, I did not receive any complaints, but on the other hand, did hear many words of praise and satisfaction with the way the veterans of the Spanish War, the Philippine Insurrection, and the China Relief Expedition were being treated. I talked with a goodly number of my veteran comrades and as far as I could discover, the situation as far as their treatment was concerned, was satisfactory.

I believe that on account of the rather small number of Spanish War veterans now being treated in the hospitals under the Veterans' Administration management, and also on the fact that our own organization, having been quite active in keeping in contact with our hospitalized veterans, both through service officers and camp members, any situation that might have grown to be a serious detriment to our veterans has either been avoided or eliminated.

I enclose a photostatic copy of the report of the service officer of the department of California, United Spanish War Veterans, dated May 17, 1945, which notes that no complaints were made, and I have not seen nor heard of any adverse Service Officer's report in our organization.

I reside in Los Angeles and under the present transportation shortage, I do not feel it necessary or proper that I travel to Washington, D. C., as the information I know is reflected in this letter. However, if you desire or request my attendance, I would promptly comply.

My comrades feel that they are and have been well treated and for the remaining years look forward to good treatment.

Yours very respectfully,  
 R. MORGAN GALBRETH,  
*Commander in Chief, United Spanish War Veterans.*

(My term expires September 12, 1945; began August 13, 1944.)

HEADQUARTERS,  
DEPARTMENT OF CALIFORNIA,  
UNITED SPANISH WAR VETERANS,  
San Francisco 2, Calif., May 17, 1945.

GEORGE A. MARSHALL,  
*Department Adjutant United Spanish War Veterans, San Francisco, Calif.*

DEAR SIR AND COMRADE: In reference to your letter of May 13, will state that I have interviewed about 40 or 50 of the members in the hospital and have not heard one to enter any complaint, as to the treatment given them.

But I was assured that they are getting as good treatment as if they paid from 35 to 40 dollars a week in other hospitals.

Hoping this will answer the question that is required, and in reference to the letter dated May 13.

I Remain Yours in F. P. & H.

SAMUEL H. STIEF,  
*Department Hospital Contact Representative,  
Veterans Administration Branch, Los Angeles, Calif.*

The CHAIRMAN. Thank you, General Hines.

General HINES. Mr. Chairman, may I say to the committee, in closing, that I appreciate the patience that you have shown in listening to me, the cooperation that you have given me during these many years, and that I will be around here for a little while—I will not turn over the Veterans' Administration, as I understand it, until the first of August—and I am available to the committee at any time.

I appreciate the courtesy that has been shown me here.

Mr. McQUEEN. May I ask just one question more, General Hines, if you have this information readily at hand, how much money has the Veterans' Administration spent for the care of veterans in all of your departments since the time you took over?

General HINES. Something over \$17,000,000,000.

Mr. McQUEEN. That is for all the services, including hospitals?

General HINES. I have a break-down of it here, I believe, and I will be glad to insert it in the record, if the committee so desires.

The CHAIRMAN. Without objection.

(The information is as follows:)

Disbursements from appropriations, March 1923 to March 1945:

Salaries and administrative expenses.....	\$1, 874, 373, 879. 72
Printing and binding.....	3, 537, 159. 72
Emergency fund for the President.....	43, 424. 85
Administrative expenses World War Adjusted Com- pensation Act.....	4, 530, 776. 15
Increase of compensation.....	2, 717, 673. 68
Military and naval compensation.....	2, 080, 446, 558. 72
Hospital facilities and services.....	19, 979, 688. 12
Hospital and domiciliary facilities.....	83, 954, 239. 83
Vocational rehabilitation.....	240, 321, 257. 93
Vocational rehabilitation revolving fund, World War II.....	71, 623. 14
Soldiers and sailors civil relief claims.....	44, 747. 98
Reliefs.....	114, 495. 01
Judgments and claims.....	933, 099. 27
Loans to veterans for transportation.....	76, 103. 36
Expositions.....	25, 846. 82
National Industrial Recovery Act.....	3, 018, 704. 79
Public Works Administration.....	13, 190, 138. 18
Emergency relief.....	33, 311. 64
Military and naval insurance.....	1, 824, 711, 609. 52
National service life insurance appropriated fund.....	419, 232, 763. 09
Adjusted service and dependent pay.....	55, 629, 771. 28
Adjusted service certificate fund.....	3, 803, 254, 637. 27
Salaries, Bureau of Pensions, 1931.....	1, 336, 920. 95
Printing and binding, Bureau of Pensions.....	10, 762. 92

## Disbursements from appropriations, March 1923 to March

1945—Continued

Investigation of pension cases.....	\$125,964.33
Salaries and expenses, Employees Retirement Act.....	109,343.30
Contingent expenses, Bureau of Pensions.....	15,090.51
Fees of examining surgeons, 1930-31.....	292,896.99
Appliances:	
Available balance transferred from War Department.....	27,025.00
Available balance transferred from Interior Department.....	197.10
Annuities to participants and beneficiaries in yellow fever experiments, 1931.....	15,750.00
Army and Navy pensions.....	5,776,486,349.38
National homes for disabled volunteer soldiers.....	2,740,587.56
Total.....	16,211,402,398.11

## Disbursements from special and trust funds, March 1923-45:

United States Government life insurance.....	641,861,657.44
National service life insurance.....	123,829,379.47
Horatio War fund.....	21,742.33
General post fund.....	3,436,171.56
Funds due incompetent veterans.....	1,528,959.09
Personal funds of patients.....	26,924,414.04
Vocational rehabilitation gift fund.....	10,972.65
Total.....	797,613,296.58

Grand total..... 17,009,015,694.69

Mrs. ROGERS. Mr. Chairman, General Hines is always on the job, and I think it is interesting that in all these years his honesty and integrity has never been questioned by anybody. In the handling of such tremendous sums of money, and with the possibility or irregularities, I think it is a very remarkable record.

The CHAIRMAN. Of course, I think General Hines has done a wonderful job, and the servicemen owe him a lasting debt of gratitude.

Mr. DOMENGEAUX. Mr. Chairman, as this may be the last time the general appears before this committee before he retires from his present position, I think it is appropriate that this committee pay tribute to General Hines for his faithful and loyal service to the Government, and I make that motion.

Mrs. ROGERS. I second the motion.

The CHAIRMAN. You have all heard the motion. All in favor say "Aye." It is so ordered.

I may say that we are going to have General Hines back with us, however.

Mrs. ROGERS. May I ask you one question on legislation before you go, General? I think you recommended to your rating board the amount of \$200 for the loss of two hands, or two feet, or the loss of one hand and one foot, and I think many of those double amputees, although their amputations may be made at the ankle, are very heavy men and they have great difficulty in managing their artificial feet.

General HINES. I really believe that the judgment of the committee, after you have heard from the service organizations and have had an opportunity to have some of these men come in from Walter Reed, ought to be followed. I would not hesitate to recommend \$25 more in those cases or \$50 more. We will have more of them in this war than we have ever had; they have a handicap, and wherever the



service has handicapped a man, I think we should be liberal. We can afford to be.

Mrs. ROGERS. And this ought to be passed at once.

General HINES. I would suggest it.

The CHAIRMAN. Thank you, General.

General HINES. Thank you, Mr. Chairman.

The CHAIRMAN. We will have you with us again, probably, before the week is out, on some other matters.

General HINES. I will be glad to come.

The CHAIRMAN. General Hines, I understand you have a list of the physicians and dentists in the various hospitals. I am going to ask you to submit them to me that I may insert at this point in the record, such list, giving the name and place of each hospital together with the name, place of birth, date of birth, and date of appointment of each physician and dentist in that hospital.

(The matter referred to follows:)

*Veterans' Administration commissioned and civilian doctors and dentists*

ALBUQUERQUE, N. MEX.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Cole, Maj. Sidney S.	Chicago, Ill.	June 15, 1910	July 6, 1938.
Foster, Lt. Col. Elden H. H.	Harrisonville, Mo.	Sept. 24, 1881	May 15, 1922.
Guller, Maj. Emanuel J.	Kiev, Russia.	Mar. 9, 1911	Sept. 6, 1941.
Merriam, Maj. Sidney A.	Montgomery, Ala.	Feb. 17, 1888	Feb. 2, 1931.
Sax, Capt. Max T.	Russia	Dec. 25, 1903	Mar. 16, 1942.
Trostier, Capt. Lewis S.	New York City, N. Y.	Oct. 7, 1910	Dec. 2, 1940.
<b>Civilian medical officers:</b>			
Ferrell, Lee T.	Hazlehurst, Miss.	Oct. 23, 1879	Dec. 15, 1920.
Mobley, Arthur	Riley, Ark.	Mar. 26, 1889	Oct. 20, 1924, to May 11, 1930; Oct. 17, 1932, to Jan. 7, 1937; Sept. 10, 1942.
<b>Civilian dental officer:</b>			
Kinzer, John D.	Bedford, Va.	May 10, 1895	Jan. 24, 1936.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officer:</b>			
Groves, Daniel C.	Brookwayville, Pa.	Jan. 9, 1878	Dec. 15, 1920.
<b>Commissioned medical officer:</b>			
Mason, First Lt. William S.	Washita County, Okla.	Aug. 17, 1896	Dec. 15, 1942.

ALEXANDRIA, LA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Adelman, Capt. Samuel I.	Philadelphia, Pa.	May 8, 1911	Nov. 19, 1940.
Altschuler, Capt. Max G.	Omaha, Nebr.	Apr. 3, 1907	Aug. 1, 1941.
Chelnek, Capt. Irving	Chicago, Ill.	Feb. 25, 1916	Dec. 1, 1941.
Cohn, Capt. Harold S.	Russia	Dec. 30, 1888	May 1, 1940.
Epstein, Capt. Isaac	New York, N. Y.	Jan. 15, 1908	Sept. 16, 1942.
Etter, Lt. Col. Roscoe	Warren County, Tenn.	Jan. 18, 1888	Jan. 6, 1931.
Ketron, Maj. Hubert W.	Pineville, Ky.	Mar. 7, 1899	Aug. 27, 1929.
Kleinman, Capt. Samuel B.	Russia	Jan. 3, 1914	Feb. 1, 1940.
Last, Maj. Jeremiah	New York City	Aug. 22, 1908	June 3, 1938.
Mathiasen, Capt. Henning W.	Omaha, Nebr.	July 17, 1908	May 1, 1941.
McClelland, Maj. Norman M.	Gilmer, Tex.	Jan. 28, 1888	Nov. 6, 1931.
Odegard, Capt. John K.	Kalispell, Mont.	Oct. 19, 1908	Aug. 1, 1941.
Pravda, Capt. Eli	New York City	Dec. 12, 1913	Mar. 2, 1942.
Schwarcz, Capt. Benjamin E.	Obestertze, Hungary	Apr. 23, 1903	Feb. 23, 1938.
Sellers, Capt. Harry W.	Ottumwa, Iowa	July 13, 1884	Apr. 1, 1944.
<b>Civilian medical officers:</b>			
Burdison, William R.	Moscow, Tenn.	July 10, 1905	July 3, 1937.
Carroll, George F.	Atlanta, Ga.	June 17, 1884	July 20, 1934.
Grubb, Donald J.	Liberty, Ill.	May 2, 1895	July 27, 1929.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## ALEXANDRIA, LA.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
<b>Civilian medical officers—Con.</b>			
Moore, Tarleton .....	McKinney, Tex.....	Dec. 22, 1884	Sept. 20, 1919.
Moore, William P.....	Smithville, Ark.....	Sept. 12, 1889	Feb. 6, 1931.
Pedicord, Reece M.....	Wheeling, W. Va.....	Feb. 7, 1882	Nov. 1, 1944.
Pitts, Wilton G.....	Hazlehurst, Miss.....	Nov. 20, 1891	Feb. 10, 1931.
Susskind, Arthur.....	New York, N. Y.....	Sept. 12, 1910	Aug. 1, 1944.
<b>Commissioned dental officer:</b>			
Baker, Maj. DeWitt T.....	Cookeville, Tenn.....	Mar. 16, 1894	Oct. 12, 1927.
<b>Civilian dental officer:</b>			
Cassidy, William J.....	Worcester, Mass.....	June 20, 1895	May 29, 1922, to Feb. 29, 1924; Aug. 8, 1942.

## AMARILLO, TEX.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Corson, Maj. Wesley C.....	Springfield, Ill.....	June 11, 1901	July 17, 1939.
Handin, Capt. Irving L.....	Russia.....	Oct. 4, 1908	Oct. 4, 1938.
Haugen, Maj. Ingvald J.....	Gilby, N. Dak.....	Apr. 9, 1897	Oct. 17, 1935.
Hendon, Lt. Col. Oma E.....	Powelson, Ga.....	June 4, 1889	Sept. 8, 1918.
Jacobson, Capt. Merlin E.....	Albion, Nebr.....	Apr. 3, 1902	Mar. 16, 1942.
Walkes, Maj. Ernest E.....	Avon, S. Dak.....	July 23, 1895	Mar. 14, 1932.
Wegener, Lt. Col. Karl F. E.....	Germany.....	Jan. 9, 1884	Jan. 15, 1923.
<b>Civilian dental officers:</b>			
Whitehead, William D.....	Durango, Colo.....	June 6, 1896	Nov. 21, 1930.

## AMERICAN LAKE, WASH.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Cullins, Col. John G.....	Junction City, Ark.....	Dec. 11, 1893	Dec. 1, 1920.
Diamond, Capt. Leon S.....	Chicago, Ill.....	Aug. 6, 1915	May 1, 1941.
Futtermann, First Lt. Samuel.....	New York, N. Y.....	Oct. 15, 1909	July 16, 1942.
Jackson, Capt. Carl R.....	Carbondale, Ill.....	July 7, 1901	1935.
Marcovitch, Maj. Joseph.....	Kisheneff, Russia.....	Feb. 6, 1900	Oct. 18, 1937.
Morgan, Maj. John D'Arcy.....	Portland, Oreg.....	Mar. 22, 1904	Apr. 9, 1935.
Simon, Capt. Werner.....	Bremen, Germany.....	June 5, 1914	Sept. 16, 1941.
<b>Civilian medical officer:</b>			
Neill, Thomas F.....	Limestone, Pa.....	Nov. 8, 1877	May 25, 1922.
<b>Commissioned dental officer:</b>			
Edele, Capt. Fred L.....	St. Louis, Mo.....	Oct. 2, 1889	Feb. 9, 1921.

## ASPINWALL, PA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Abramovitz, Capt. Leonard J.....	Baltimore, Md.....	Jan. 29, 1911	Dec. 1, 1941.
Barone, Maj. Andrew M.....	Fredonia, N. Y.....	Jan. 29, 1908	Jan. 17, 1938.
Carroll, Col. Kelso A.....	Dudley, Ga.....	Feb. 14, 1894	May 11, 1932.
Cohen, Maj. Archibald C.....	Clarks Harbor, Nova Scotia, Canada.....	Feb. 13, 1909	July 8, 1940.
Fellows, Lt. Col. William W.....	Salisbury, Mo.....	Dec. 9, 1896	June 18, 1931.
Fronduiti, Capt. Lucian J.....	Jessup, Pa.....	Dec. 13, 1907	Nov. 1, 1939.
Geer, Capt. Joseph A.....	Lancaster, Ohio.....	Mar. 16, 1914	June 1, 1942.
Glushien, Maj. Arthur S.....	Brooklyn, N. Y.....	July 15, 1911	Jan. 12, 1939.
Goodman, Capt. David H.....	Wilmington, Del.....	Nov. 25, 1908	Nov. 2, 1942.
Huber, Maj. Charles B.....	Lancaster, Pa.....	Aug. 17, 1900	Mar. 1, 1937.
Machover, Capt. Saul.....	New York, N. Y.....	Nov. 11, 1909	May 1, 1941.
McClung, Lt. Col. Marshall L.....	Charleston, W. Va.....	July 21, 1895	Aug. 15, 1920.
Pullen, First Lt. Lee.....	United States.....	July 13, 1913	June 5, 1943.
Rumball, Maj. John M.....	Rochester, N. Y.....	Apr. 20, 1909	July 8, 1940.
Schwartz, Maj. Robert.....	Brooklyn, N. Y.....	July 28, 1910	Oct. 4, 1938.
<b>Civilian medical officers:</b>			
Bloom, Charles Francis.....	Viola, Iowa.....	Feb. 5, 1881	Feb. 3, 1931.
Buka, Alfred J.....	Pittsburgh, Pa.....	May 1, 1882	Apr. 24, 1944.
Burkhart, Helen W.....	do.....	Aug. 10, 1913	Sept. 18, 1944.
Ebersson, Frederick.....	New York, N. Y.....	Feb. 10, 1892	Oct. 17, 1938, to Aug. 15, 1940; Aug. 24, 1942.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## ASPINWALL, PA.—Continued

Name	Place of birth	Date of birth	Date of appointment
MEDICAL AND HOSPITAL SERVICE—CON.			
Civilian medical officers—Con.			
Ecker, Charles S.	Oakmont, Pa.	Jan. 5, 1881	Jan. 10, 1944.
Hammond, James L.	Lebanon, Ind.	Apr. 28, 1878	Feb. 15, 1922.
Ketterer, Clarence H.	Butler, Pa.	Jan. 13, 1887	Mar. 25, 1921.
Kirk, Donald J.	Pittsburgh, Pa.	Dec. 13, 1889	Apr. 17, 1944.
O'Donnell, Merrill C.	Minneapolis, Minn.	Aug. 16, 1915	Jan. 17, 1944.
Rauch, Stewart E.	Bethlehem, Pa.	June 30, 1894	Apr. 24, 1944.
Commissioned dental officers:			
Ewing, First Lt. Frederick M.	Salisbury, Pa.	July 15, 1897	Sept. 10, 1942.
Lee, Maj. Walter S.		Jan. 2, 1896	Oct. 6, 1920.
Rushmer, Capt. Linden A.	Oakland, Calif.	Oct. 27, 1905	May 23, 1941.
Weil, First Lt. Ely.	New York City, N. Y.	Sept. 26, 1908	Aug. 1, 1944.

## ATLANTA, GA.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Abrams, Capt. Hayman Seelig.	Poland.	Apr. 12, 1903	June 9, 1937.
DiLorenzo, Capt. Gaspare.	Sicily, Italy.	Apr. 24, 1904	Oct. 16, 1941.
Frischberg, Capt. Samuel B.	Kovel, Russia.	Feb. 24, 1896	Apr. 1, 1942.
Krantz, Maj. Simon.	New Haven, Conn.	Dec. 23, 1905	Nov. 11, 1935.
Mestre, Maj. Ricardo.	Mayaguez, P. R.	May 20, 1889	July 14, 1919.
Rosen, Capt. Leonard B.	Fitchburg, Mass.	Dec. 24, 1907	Aug. 1, 1941.
Steiner, Capt. William E.	Shawneetown, Ill.	May 22, 1914	Feb. 2, 1940.
Thurston, Lt. Col. John A.	Thomaston, Ga.	June 12, 1892	Aug. 20, 1920.
Civilian medical officers:			
Beall, Charles R.	Philadelphia, Pa.	Feb. 16, 1897	Aug. 1, 1939.
Bryant, Roy H.	Calhoun, Ga.	Nov. 24, 1889	Oct. 11, 1920.
Daniel, Robert L.	Union Point, Ga.	Feb. 10, 1894	Dec. 28, 1923.
Daniels, William.	Chicago, Ill.	Dec. 7, 1884	Dec. 17, 1931.
Foster, Simon S.	No record available.	Jan. 22, 1887	Dec. 6, 1927.
Hall, John H.	Woodsdale, N. C.	May 21, 1885	Sept. 11, 1922.
McAllister, James.	Mount Vernon, Ga.	Oct. 3, 1892	Sept. 1, 1938.
Nellans, Charles.	South Bend, Ind.	June 18, 1894	July 1, 1930.
Thompson, William C.	Anderson County, S. C.	Dec. 16, 1883	Oct. 16, 1944.
Williamson, Milton.	No record available.	Mar. 3, 1893	May 15, 1944.
Commissioned dental officer:			
Boston, Capt. John A.	Warrenton, Va.	July 14, 1889	Feb. 26, 1936.
Civilian dental officers:			
Pettinger, Neil S.	No record available.	Aug. 16, 1907	May 15, 1944.
Wells, Robert F.	Stone Mountain, Ga.	June 22, 1891	July 29, 1920.
ADJUDICATION ACTIVITIES			
Civilian medical officers:			
Arthur, James F.	St. Matthews, S. C.	Aug. 19, 1889	June 9, 1922.
Holden, Farish C.	Johntown, Ga.	Feb. 14, 1900	Jan. 22, 1945.
Lahman, Rose A.	Toronto, Canada.	Oct. 2, 1907	Feb. 7, 1944.
Longino, Dick R.	Douglas County, Ga.	July 20, 1888	Jan. 30, 1929.
Teusoch, Herbert L.	Atlanta, Ga.	Apr. 3, 1900	Apr. 3, 1944.
Williams, David.	Ashville, Ala.	May 19, 1886	Apr. 1, 1944.

## AREA OFFICE NO. 4, ATLANTA, GA.

ADJUDICATION ACTIVITIES			
Civilian medical officers:			
Aimand, Claude.	Lithonia, Ga.	Jan. 3, 1891	July 1, 1921.
Carter, Donald E.	Nashville, Ga.	Jan. 11, 1895	Feb. 1, 1944.
Miller, Walter.	No record available.	Sept. 15, 1877	Jan. 9, 1945.
Tryon, Lewis Roger.	Hamburg, Pa.	Mar. 22, 1872	Apr. 1, 1944.
Turest, David.	Lithuania, Province of Kaunos.	Dec. 25, 1902	June 23, 1941.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## AUGUSTA, GA.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Burdashaw, Maj. William J.....	Atlanta, Ga.....	July 9, 1900	Apr. 1, 1932.
Feinberg, Capt. Philip.....	Sioux City, Iowa.....	Apr. 14, 1915	1941.
Gancher, Capt. Ralph.....	Waterbury, Conn.....	Dec. 28, 1915	Mar. 16, 1942.
McElroy, Capt. Robert B.....	Rogers, Tex.....	Jan. 9, 1912	July 8, 1940.
Miracolo, First Lt. Charles C.....	Italy.....	Jan. 1, 1907	Nov. 2, 1942.
Scheinman, Capt. Leonard.....	New York, N. Y.....	Mar. 28, 1909	Mar. 16, 1943.
Tighe, Maj. Leo R.....	Cohoes, N. Y.....	Aug. 13, 1890	Oct. 1, 1928.
Vicary, Maj. William H.....	Lockport, N. Y.....	Sept. 6, 1909	Oct. 1937.
Walton, Lt. Col. Charles R.....	Benton, Ark.....	Feb. 7, 1894	Mar. 8, 1922.
<b>Civilian medical officers:</b>			
Clayton, Malcolm D.....	Roy, Ga.....	Aug. 31, 1888	May 14, 1921.
Hutchison, Sam L.....	Belden, Miss.....	Nov. 18, 1902	June 11, 1936.
Witten, Henry O.....	Coffey, Mo.....	Feb. 13, 1886	Oct. 1, 1920 to Jan. 10, 1926, Sept. 1, 1928.
<b>Civilian dental officer:</b>			
Skinner, Edward J.....	New Orleans, La.....	Sept. 25, 1891	Oct. 17, 1922.

## BALTIMORE AREA, OFFICE NO. 3

<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Richards, Dickinson.....	Alton, Iowa.....	May 17, 1893	Dec. 23, 1944.
Forney, Guy V.....	Peru, Ind.....	June 20, 1889	Dec. 20, 1927.

## BALTIMORE REGIONAL OFFICE, BALTIMORE, MD.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Baird, Maj. Paul E.....	Winchester, Ohio.....	June 6, 1903	Sept. 2, 1938.
Di Iorio, Capt. Edward L.....	Newark, N. J.....	Nov. 17, 1911	Dec. 1, 1941.
Fox, Maj. Nathan S.....	Berezdov, Russia.....	Apr. 22, 1896	July 6, 1937.
Glickman, Maj. Leo G.....	No record available.....	Oct. 22, 1899	Sept. 26, 1926.
Isen, Capt. Paul J.....	Maspeth, Long Island, N. Y.....	Oct. 25, 1914	May 1, 1941.
Ludwig, Capt. Irving I.....	Chicago, Ill.....	Jan. 25, 1905	Nov. 16, 1931.
<b>Commissioned dental officer:</b>			
Vickery, Capt. Arthur L.....	Rock Stream, N. Y.....	Aug. 6, 1894	Oct. 21, 1926.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officer:</b>			
Carroll, Charles J.....	Dennisville, N. J.....	Dec. 16, 1872	Dec. 29, 1943.

## BATAVIA, N. Y.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Badaines, Maj. Nathaniel H.....	Poland.....	Apr. 20, 1902	Mar. 23, 1939.
Bogen, Maj. Eugene F.....	Finland.....	Nov. 4, 1886	May 23, 1934.
Bonner, Maj. William F.....	Bastrop, La.....	Dec. 25, 1884	May 1, 1937.
Cajigas, Capt. Mariano.....	Puerto Rico.....	Sept. 8, 1905	Aug. 9, 1935.
Catinella, Capt. Anthony S.....	New York, N. Y.....	Apr. 15, 1908	July 16, 1942.
Eisert, Capt. Otto.....	do.....	July 6, 1912	Sept. 16, 1942.
Jolly, Lt. Lewis E.....	No record available.....	Mar. 3, 1912	Apr. 16, 1940.
Kirsh, Maj. Israel E.....	Russia.....	Mar. 17, 1906	Feb. 11, 1938.
Korol, Maj. Epharim.....	do.....	Aug. 15, 1894	Aug. 15, 1920.
Locke, Lt. Col. Frederick C.....	Vevay, Ind.....	Jan. 24, 1884	July 25, 1920.
Roadruck, Capt. Roscoe D.....	Albion, Nebr.....	Nov. 7, 1905	July 5, 1938.
Sorenson, Lt. Col. Raymond.....	Erwin, S. Dak.....	Jan. 15, 1904	Sept. 4, 1934.
<b>Civilian medical officer:</b>			
Newlove, Frank E.....	Winnepeg, Mass.....	Oct. 24, 1890	Apr. 1, 1942.
<b>Commissioned dental officer:</b>			
Day, Capt. Milligan E.....	Georgia.....	Feb. 7, 1889	May 24, 1922.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## BATAVIA, N. Y.—Continued

Name	Place of birth	Date of birth	Date of appointment
ADJUDICATION ACTIVITIES			
Commissioned medical officers:			
Blanchette, Lt. Louis A.....	Montreal, Canada.....	Aug. 15, 1888	June 19, 1944.
Trott, Capt. Harold William.....	Canada.....	Aug. 7, 1899	Jan. 25, 1944.
Civilian medical officers:			
Malonson, James H.....	Gloucester, Mass.....	Dec. 20, 1876	Jan. 3, 1921 to June 1921, July 12, 1921, to Jan. 15, 1940, May 1, 1941.
McDowell, John S.....	Plattsburg, N. Y.....	June. 1, 1894	Feb. 21, 1944.
Waglom, Wesley W.....	New York, N. Y.....	June 18, 1881	Feb. 25, 1944.

## BATH, N. Y.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Alexander, Maj. Ralph E.....	New York, N. Y.....	Oct. 22, 1912	Dec. 2, 1940.
Alvermann, Capt. Emil.....	Germany.....	June 2, 1908	July 9, 1937.
Bolin, Maj. Neatha V.....	Cleveland, Kans.....	Aug. 31, 1905	Jan. 16, 1939.
Feldberg, Capt. Irving.....	New York, N. Y.....	July 21, 1904	Feb. 3, 1941.
Giacomini, Capt. Antonio J.....	Wallingford, Conn.....	June 9, 1906	May 1, 1941.
Kates, Maj. Samuel R.....	Cleveland, Ohio.....	Aug. 15, 1908	Feb. 17, 1937.
Knoll, Capt. William.....	New York, N. Y.....	Dec. 29, 1904	Dec. 2, 1940.
Koretz, Capt. Harold.....	Detroit, Mich.....	Jan. 18, 1910	Jan. 10, 1938.
Lipton, Capt. Benjamin.....	Corona, Long Island, N. Y.....	Dec. 20, 1907	Feb. 3, 1941.
Salberg, Capt. Seymour E.....	Chicago, Ill.....	Jan. 25, 1910	Mar. 2, 1942.
Civilian medical officers:			
Steindler, Leo.....	Baltimore, Md.....	Oct. 17, 1886	Nov. 1, 1921.
Woodward, Roy.....	Steuben County, N. Y.....	May 12, 1889	Oct. 20, 1920.
Commissioned dental officers:			
Hoos, Capt. Herman H.....	Brooklyn, N. Y.....	Sept. 26, 1907	Nov. 2, 1939.
Civilian dental officers:			
Endler, Joseph C.....	West Hoboken, N. Y.....	Apr. 7, 1892	Oct. 1, 1923.
Hodges, Lowell B.....	Oak Forrest, Tex.....	June 4, 1896	Mar. 24, 1925.

## BAY PINES, FLA.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Baranowski, Capt. Joseph A.....	No record available.....	Mar. 3, 1908	May 1, 1941.
Barnett, Carp. Ernest R.....	do.....	Nov. 11, 1912	Jan. 8, 1945.
Bevis, Lt. Col. William M.....	Boscom, Fla.....	Oct. 16, 1882	Oct. 8, 1928.
Deane, Capt. Harry R.....	Chicago, Ill.....	Oct. 21, 1909	Mar. 1, 1938.
Gorday, Capt. Abraham J.....	do.....	Apr. 30, 1914	Aug. 29, 1938.
Hanks, Maj. George W.....	Panguitch, Utah.....	Mar. 14, 1892	Dec. 23, 1930.
Jones, Lt. Col. Will O'D.....	Milledgeville.....	Mar. 5, 1888	Feb. 20, 1932.
Karmioli, Capt. Jerome.....	Brooklyn, N. Y.....	Jan. 3, 1910	Feb. 3, 1941.
Keller, Maj. Julian J.....	Birmingham, Ala.....	Sept. 21, 1903	Jan. 9, 1935.
Klapman, Capt. Martin J.....	Chicago, Ill.....	Oct. 5, 1913	May 1, 1941.
Manginelli, Capt. Vitus W.....	New York, N. Y.....	May 18, 1905	July 8, 1940.
Range, Maj. Irving.....	Ulster, N. Y.....	July 24, 1896	Mar. 12, 1937.
Rock, Maj. John W.....	Paducah, Ky.....	June 9, 1889	Feb. 16, 1922.
Sieger, Maj. Simon.....	Ostrow Lomza, Poland.....	Dec. 25, 1901	Sept. 1, 1937.
Simon, Capt. Sydney M.....	Bronx, N. Y.....	July 23, 1908	Sept. 16, 1942.
Civilian medical officers:			
Barnett, Ernest R.....	No record available.....	Nov. 11, 1912	Jan. 8, 1945.
Hughes, Charles W.....	Wisconsin.....	Mar. 9, 1877	June 6, 1923.
Nelson, James Van D.....	Logansport, Ind.....	May 1, 1878	Aug. 15, 1921.
Nelson, Roger W.....	Quincy, Mass.....	Nov. 2, 1897	May 26, 1939.
Thaler, Henry S.....	Austria.....	Aug. 20, 1904	June 23, 1941.
Thompson, William J.....	Oneonta, N. Y.....	Aug. 3, 1882	Aug. 4, 1944.
Wendriner, Herbert V.....	Breslau, Germany.....	Nov. 14, 1879	July 4, 1944.
Commissioned dental officers:			
Hatcher, Maj. William H.....	Allen, Ky.....	Mar. 15, 1893	May 1, 1920.
Judge, Capt. Newell T.....	Carbondale, Pa.....	Nov. 15, 1897	Aug. 8, 1923.
Lonnegan, First Lt. Joseph A.....	New Orleans, La.....	Mar. 27, 1909	Feb. 6, 1941.
ADJUDICATION ACTIVITIES			
Civilian medical officers:			
Fleming, Mary R.....	Monterey, Va.....	Apr. 17, 1877	Feb. 15, 1944.
Smith, Ray W.....	Newport, Ga.....	June 9, 1889	Feb. 2, 1924.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## BEDFORD, MASS.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Burrier, Lt. Col. Walter P.....	Biddeford, Maine.....	Apr. 12, 1882	Nov. 19, 1921.
Edelstein, Capt. Abraham.....	Austria-Hungary.....	Oct. 24, 1916	June 1, 1942.
Meislin, Capt. Jacob.....	Kremenchug, Russia.....	July 4, 1907	Aug. 1, 1941.
Mercurio, Capt. Frank.....	New York City.....	June 26, 1912	Do.
O'Brien, Maj. John F.....	Fall River, Mass.....	Aug. 12, 1886	Apr. 4, 1928.
Weber, Capt. Joseph E.....	Milwaukee, Wis.....	June 17, 1910	May 6, 1938.
Zellin, Maj. Morris.....	Boston, Mass.....	Aug. 12, 1897	May 21, 1924.
<b>Civilian medical officers:</b>			
Adams, Winthrop.....	Cambridge, Mass.....	May 18, 1887	Sept. 26, 1919.
Blumenthal, Irving J.....	New York City.....	Dec. 14, 1910	May 1, 1941.
Braverman, Aaron H.....	Chelsea, Mass.....	Mar. 18, 1897	Jan. 15, 1923.
Richter, Waldemar G.....	Fargo, N. Dak.....	Jan. 14, 1892	Dec. 1, 1925, to Dec. 31, 1926; Mar. 6, 1927.
<b>Commissioned dental officers:</b>			
Schuman, First Lt. Elihu L.....	Brooklyn, N. Y.....	July 18, 1906	July 1, 1941.
<b>Civilian dental officers:</b>			
Sinton, William.....	Colorado Springs, Colo.....	May 5, 1883	July 1, 1921.

## BILOXI, MISS.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Burns, Lt. Col. Ellis P.....	Birmingham, Ala.....	July 4, 1886	June 15, 1922.
Hard, Maj. Wilbur L.....	Camp Hill, Ala.....	Jan. 12, 1889	Jan. 22, 1937.
Hille, Maj. Richard W.....	Norfolk, Nebr.....	Oct. 2, 1898	Jan. 5, 1932.
Iseman, Capt. Robert M.....	Cleveland, Ohio.....	Feb. 10, 1912	Feb. 3, 1941.
Manning, Maj. Wilkins R., Jr.....	No record available.....	Apr. 30, 1910	Nov. 1, 1941.
Pruett, Capt. William V.....	Aberdeen, Miss.....	Apr. 22, 1888	May 31, 1930.
<b>Civilian medical officers:</b>			
Haslitt, Percy P.....	Marshall, Ill.....	May 7, 1880	Mar. 17, 1922.
Henry, Hugh B.....	Bluff City, Ark.....	Mar. 16, 1890	Dec. 1, 1924.
Larde, Charles D.....	Salvadore, France.....	Jan. 16, 1898	Aug. 16, 1944.
<b>Commissioned dental officers:</b>			
Roberts, Capt. Thomas N.....	Somerset, Ky.....	July 7, 1893	Apr. 10, 1921.

## BOISE, IDAHO

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Allis, Maj. Sherman L.....	Kansas City, Mo.....	May 15, 1911	Oct. 5, 1938.
Davis, Maj. Ralph E.....	Foster, Mo.....	Oct. 17, 1891	Nov. 1, 1920.
Harris, Maj. Henry C.....	Wake County, N. C.....	July 28, 1893	Apr. 8, 1931.
Kimelman, Capt. Nathan.....	Warsaw, Poland.....	Feb. 18, 1912	May 1, 1941.
Schuell, Maj. Gerald J.....	Parnell, Iowa.....	Mar. 14, 1894	Mar. 6, 1934.
Schulz, Lt. Col. Arthur W.....	Chicago, Ill.....	Mar. 30, 1892	July 16, 1928.
<b>Commissioned dental officers:</b>			
Bouchet, Capt. Herman.....	Montreal, Canada.....	Feb. 21, 1898	Apr. 15, 1921.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Downs, Joseph M.....	Chicago, Ill.....	Feb. 7, 1890	Jan. 17, 1944.

## BOSTON, MASS.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Johnson, Capt. Goodwin A.....	Keene, N. H.....	Feb. 10, 1891	Aug. 30, 1920.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Commissioned medical officers:</b>			
Berenson, Capt. Wyman.....	Zaslov, Russia.....	Nov. 28, 1897	July 22, 1942.
<b>Civilian medical officers:</b>			
Fasanello, John Baptist.....	Casano Al Jona, Italy.....	Mar. 7, 1900	Jan. 19, 1944.
Kewer, Leo T.....	Boston, Mass.....	Apr. 13, 1888	Oct. 18, 1928.
Quirk, Thomas C.....	Watertown, Mass.....	Jan. 6, 1889	Feb. 1, 1944.



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## BRECKSVILLE, OHIO

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Deucher, Capt. Richard G.	Cleveland, Ohio	May 3, 1914	July 16, 1942.
Dredge, Maj. Thomas E.	Belview, Minn.	Sept. 3, 1902	Nov. 10, 1930.
Gilfoy, Maj. Francis E.	Adams, Mass.	Aug. 10, 1901	Mar. 6, 1935.
Halberstein, 1st Lt. Abraham	Warsaw, Poland	July 28, 1902	Sept. 16, 1942.
Harris, Capt. Michael A.	Central Falls, R. I.	Sept. 21, 1911	Feb. 3, 1941.
Rueggesser, Maj. Franklin M.	Baltic, Ohio	Nov. 27, 1899	Sept. 11, 1931.
Schneider, Capt. Irving M.	New York, N. Y.	Jan. 13, 1914	May 1, 1941.
Civilian medical officers:			
Bearden, Fred	Solgohaehia, Ark.	Dec. 10, 1884	Nov. 5, 1920.
Bradford, Wm. H.	Nankipoo, Tenn.	Feb. 11, 1901	July 1, 1928.
Cass, James W.	Maumee, Ohio	Sept. 20, 1882	Mar. 1, 1922.
Pomerantz, Max M.	New York, N. Y.	June 5, 1909	Mar. 18, 1944.
Post, Edward	South Bend, Ind.	Oct. 10, 1898	Oct. 26, 1934.
Trockey, Sidney	Chicago, Ill.	Jan. 10, 1889	Nov. 19, 1941.
Ujhely Valentine	Budapest, Hungary	July 9, 1896	May 1, 1931.
Commissioned dental officer:			
Eisenberg, Capt. Max M.	New York City	May 3, 1911	Jan. 18, 1943.
Civilian dental officer:			
Koch, Harvey	Sumner, Iowa	Oct. 25, 1892	Sept. 1, 1920.
<b>ADJUDICATION ACTIVITIES</b>			
Civilian medical officers:			
Ward, Harry H.	North Girard, Pa.	Feb. 5, 1878	Aug. 27, 1923.

## BRONX, N. Y.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Balcer, Maj. Edwin A.	Chicago, Ill.	Mar. 10, 1911	Oct. 1, 1940.
Barnett, Capt. Jack J.	New York City, N. Y.	Aug. 31, 1912	Aug. 1, 1941.
Begenau, Capt. Vernon G.	Peekskill, N. Y.	July 1, 1914	Jan. 4, 1943.
Bergmann, Capt. Charles S.	New York, N. Y.	Sept. 13, 1890	Aug. 17, 1921.
Blum, Capt. Samuel D.	do	Sept. 1, 1907	Mar. 3, 1941.
Brooks, Capt. Louis	Russia	Oct. 31, 1884	May 12, 1921.
Carotenuto, Capt. Ralph J.	New York, N. Y.	Feb. 15, 1907	Nov. 25, 1938.
Caruso, Capt. Anthony T.	Newark, N. J.	Mar. 10, 1911	Dec. 1, 1939.
Casessa, Capt. Philip R.	Sicily, Italy	June 6, 1909	July 1, 1942.
Cook, Col. Robert C.	Bradley, S. Dak.	Mar. 28, 1887	Aug. 16, 1919.
Davidhoff, Capt. Morris	New York, N. Y.	Jan. 15, 1900	Dec. 3, 1931.
Deutschman, Capt. Reynold	Cleveland, Ohio	Dec. 7, 1913	Sept. 16, 1942.
Diamond, Capt. Norman	Brooklyn, N. Y.	Aug. 2, 1914	Aug. 1, 1941.
D'Oronzio, Capt. George B.	New York City	Feb. 27, 1901	Apr. 1, 1942.
Eichenholtz, Maj. Sidney N.	Tarneu, Austria	Mar. 16, 1909	Feb. 17, 1937.
Epstein, Capt. Jacob I.	New York City	May 28, 1903	Mar. 10, 1941.
Flowers, Lt. Col. Hiland L.	do	June 13, 1894	Dec. 1, 1928.
Frankel, Capt. Samuel	Philadelphia, Pa.	July 28, 1909	Aug. 1, 1941.
Gellis, Capt. Sydney A.	New York City	Dec. 15, 1906	May 16, 1936.
Gennis, Capt. Joseph	do	Feb. 1, 1912	Jan. 15, 1940.
Glasser, Capt. Samuel M.	do	Oct. 28, 1908	Oct. 21, 1938.
Gruenbaum, Capt. Max	Bucharest, Rumania	Nov. 7, 1886	May 14, 1921.
Hardegree, Lt. Col. Harvey C.	Newman, Ga.	Feb. 4, 1891	Sept. 14, 1921.
Joseph, Capt. Julius M.	Bronx, N. Y.	Oct. 6, 1910	July 13, 1944.
Kapp, Maj. Louis A.	Koretz, Poland	June 25, 1888	May 9, 1936.
Karlen, Capt. Saul H.	New York, N. Y.	Dec. 5, 1909	Feb. 3, 1941.
Katz, Capt. Michael M.	do	Oct. 20, 1910	July 16, 1942.
Katz, Capt. Sidney	do	May 27, 1917	July 16, 1942.
Kemick, Capt. Irvin B.	Dubno, Poland	Nov. 14, 1912	Aug. 1, 1941.
Kessler, Maj. Harry	New York City	Oct. 12, 1906	Oct. 21, 1935.
Klein, Capt. Jacob	do	Apr. 26, 1910	Dec. 2, 1940.
Labruier, Capt. Frederick J.	do	Sept. 6, 1884	Jan. 21, 1944.
La Canna, Capt. Ralph L.	Mayfield, Pa.	Sept. 26, 1904	Mar. 16, 1942.
Lattman, Capt. Morris	Russia	Aug. 16, 1896	July 16, 1936.
Luloff, Capt. Harry	New York City	Jan. 11, 1911	Mar. 2, 1942.
Marshall, Maj. Louis R.	Cleveland, Ohio	Dec. 11, 1899	Nov. 9, 1934.
Matte, Maj. Michael L.	Gile, Wis.	Mar. 12, 1910	July 6, 1937.
Mayer, Capt. Hyman R.	New York City	July 29, 1911	Dec. 1, 1941.
Miller, Capt. Joseph S.	No record available.	Oct. 28, 1909	Mar. 16, 1938.
Moreland, Lt. Col. Randall	Madison, Ind.	June 28, 1904	Oct. 20, 1932.
Olson, Lt. Col. Ernest S.	Lemont, Ill.	Mar. 24, 1901	Nov. 16, 1931.
Pfeiffer, Capt. Jacob J.	Brooklyn, N. Y.	July 2, 1889	Mar. 7, 1921.
Pinks, Maj. David K.	Jersey City, N. J.	Aug. 25, 1910	Nov. 1, 1939.
Podryski, Capt. Vladimir	Russia	Dec. 25, 1903	Apr. 1, 1942.
Porter, First Lt. Louis	do	Nov. 15, 1911	Sept. 1943.
Priviteri, Capt. Chas. A.	Sicily, Italy	Jan. 1, 1910	Oct. 10, 1938.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## BRONX, N. Y.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
<b>Commissioned medical officers—Con.</b>			
Povlin, Capt. Sheppard S.	New York City	July 1, 1900	Nov. 22, 1943.
Robinson, Maj. Adrian M.	Walnut, Iowa	Nov. 20, 1904	Nov. 16, 1934.
Roswit, Capt. Bernard	Brooklyn, N. Y.	Mar. 12, 1910	Feb. 23, 1937.
Schneck, Capt. Jack I.	Bronx, New York City	Aug. 10, 1903	Jan. 15, 1940.
Schneider, Capt. Julius	New York City	June 6, 1912	Dec. 2, 1940.
Schneider, Capt. William A.	Minsk, Russia	Mar. 12, 1901	Mar. 16, 1942.
Sheimmel, Maj. Archie	Brest, Poland	Jan. 15, 1906	Aug. 23, 1940.
Spivack, Capt. Louis L.	New York City	Aug. 17, 1904	July 1, 1931.
Steingold, Capt. Meyer	Norfolk, Va.	Dec. 7, 1912	Jan. 15, 1940.
Straus, Capt. Bernard	New York City	July 30, 1911	Jan. 4, 1944.
Tepperberg, Capt. Irving	do	Oct. 6, 1908	Mar. 1, 1938.
Toomey, Maj. Joseph H.	New Brunswick, Canada	Feb. 28, 1884	July 19, 1919.
Young, Capt. William J.	Boston, Mass.	Sept. 9, 1881	June 3, 1930.
Zane, Capt. Manuel D.	Chattanooga, Tenn.	Jan. 4, 1913	Feb. 2, 1941.
<b>Civilian medical officers:</b>			
Abramson, Clarence	No record available	July 10, 1909	Aug. 23, 1944.
Cohn, Franklin	Philadelphia, Pa.	Oct. 10, 1883	June 13, 1931.
Donovan, Timothy S.	Lawrence, Mass.	Dec. 27, 1876	Dec. 14, 1920.
Emanuele, Louis J.	New York City	Feb. 25, 1908	July 8, 1940.
Ferrara, James A.	Portocannone, Italy	Feb. 5, 1896	Oct. 22, 1941.
Fuller, Allen G.	Greenville, Mich.	Nov. 17, 1880	June 8, 1920.
Fuller, Robert G.	Shiloh, La.	Apr. 9, 1887	Mar. 16, 1929.
Kreuger, Frich G.	Lemgo, Germany	Dec. 23, 1903	Apr. 24, 1945.
Lancer, John J.	No record available	Jan. 30, 1886	1925.
Lindenauer, Harold	New York City	Oct. 26, 1907	Dec. 2, 1944.
Mattice, Eugene	Pueblo, Colo.	May 6, 1888	Oct. 15, 1919.
Minden, Bendix S.	No record available	Sept. 11, 1896	Aug. 17, 1944.
Mittleman, A. A.	Brooklyn, N. Y.	Aug. 6, 1912	Feb. 3, 1941.
Scannell, Edward	Concord, N. H.	Feb. 16, 1876	Sept. 17, 1932.
Schwartz, Joseph A.	New York City	May 10, 1910	Dec. 29, 1943.
Shimberg, Mandel	Troy, N. Y.	Oct. 16, 1894	Sept. 16, 1931.
Silver, Jonas	New York, N. Y.	Oct. 17, 1902	Apr. 24, 1944.
Souther, Robert F.	Boston, Mass.	Feb. 15, 1876	Jan. 27, 1933.
Steinberg, Miguel	Plonek, Russia	May 10, 1888	Aug. 4, 1944.
Verner, William W.	Pittsburgh, Pa.	Nov. 7, 1875	Jan. 23, 1922.
Young, James J. L.	New York City	Mar. 23, 1876	Aug. 15, 1920.

## CANANDAIGUA, N. Y.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Bobowiec, Capt. Basil B.	Adams, Mass.	June 21, 1911	Aug. 1, 1941.
Cinder, 1st Lt. Julius	New York City	Jan. 11, 1913	Mar. 1, 1943.
Constantine, Capt. Oleinick P.	Luchyn, Poland	Oct. 22, 1908	Sept. 25, 1943.
Dell Cort, Capt. Amerigo P.	Brooklyn, N. Y.	June 18, 1907	July 8, 1940.
Levy, Maj. Edwin M.	St. Mary Parish, La.	June 17, 1895	Mar. 7, 1930.
Ranno, Capt. Frederick S.	New York City	June 5, 1910	May 1, 1941.
Rubin, Maj. Emanuel	Brooklyn, N. Y.	May 6, 1904	Jan. 16, 1935.
Slocum, Capt. Yudell K.	Clifton Forge, Va.	June 5, 1904	Oct. 19, 1942.
<b>Civilian medical officers:</b>			
Borden, Parker G.	Downesville, N. Y.	Jan. 16, 1879	June 24, 1920; May 1, 1927; Sept. 4, 1927.
Hansen, Hans	Denmark	Mar. 24, 1878	Jan. 15, 1923.
Mueller, Donald F.	Dyersville, Iowa	Feb. 18, 1912	June 1, 1942.
Wafer, Raymond F.	Hornell, N. Y.	Feb. 12, 1880	Jan. 7, 1928.

## CASTLE POINT, N. Y.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Ballou, Maj. DeForrest, Jr.	Philadelphia, Pa.	Mar. 21, 1885	June 15, 1925.
Bates, Col. Carleton	New Jersey	Dec. 30, 1883	June 16, 1919.
Beloff, Capt. Lewis	Philadelphia, Pa.	Sept. 23, 1912	July 1, 1942.
Emma, Capt. Edwin	Brooklyn, N. Y.	June 14, 1912	Mar. 2, 1942.
Goldstein, Capt. Leon	do	Sept. 23, 1914	Do.
Greer, Maj. Rex E.	Woodford, Okla.	Jan. 13, 1907	Sept. 16, 1938.
Hartman, Capt. Joseph	Pap, Hungary	Mar. 11, 1906	Feb. 2, 1942.
Huenagel, Lt. Col. Charles J.	Dale, Ind.	Feb. 17, 1888	Jan. 17, 1936.
Lande, Maj. Frank	Brest-Litovis, Russia	Apr. 2, 1888	Feb. 24, 1931.
Lerner, Capt. George	Philadelphia, Pa.	Sept. 4, 1906	Mar. 1, 1938.
Schumann, 1st Lt. David P.	Jersey City, N. J.	Feb. 25, 1913	Jan. 17, 1944.
Tedesco, Maj. Joseph F.	New York City, N. Y.	Sept. 23, 1912	Dec. 2, 1940.
Trevisano, Maj. Anthony	Palercres, Italy	July 21, 1890	Mar. 1, 1923.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## CASTLE POINT, N. Y.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—Con.</b>			
<b>Civilian medical officers:</b>			
Andreyko, George .....	Austria .....	Feb. 12, 1899	Nov. 13, 1944.
Breslin, James .....	Ireland .....	Nov. 11, 1877	July 13, 1922.
Keirans, James E. ....	Willimantic, Conn. ....	Aug. 8, 1898	Mar. 21, 1928.
Michelson, Nicholas .....	Riga, Latvia .....	Dec. 3, 1897	July 3, 1944.
Sloat, Harrison .....	Watertown, N. Y. ....	July 20, 1878	Feb. 12, 1922.

## CHEYENNE, WYO.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Allegretti, Lt. Col. Anthony J. ....	Chicago, Ill. ....	Nov. 1, 1907	Mar. 19, 1936.
Clarke, Capt. Edward J. ....	Anselma, Nebr. ....	July 25, 1898	Nov. 2, 1931.
Glicksman, Capt. Herbert Y. ....	Bronx, N. Y. ....	Aug. 16, 1914	Nov. 1, 1941.
Griffin, Maj. Jack B. ....	El Reno, Okla. ....	May 15, 1912	Oct. 1, 1940.
Steele, Maj. Ashby B. ....	Benton, Ark. ....	Nov. 8, 1901	Mar. 1, 1931.
Stone, Capt. Calvin F. ....	Chicago, Ill. ....	Sept. 19, 1910	Nov. 16, 1942.
Winsberg, Maj. James A. ....	do .....	May 2, 1910	Sept. 17, 1938.
<b>Civilian medical officers:</b>			
Savage, Nephi H. ....	St. George, Utah. ....	Feb. 19, 1892	July 1, 1944.

## CHICAGO, ILL., AREA No. 6

<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Bisdorf, Mathais .....	Cologne, Germany .....	June 3, 1881	Jan. 24, 1944.
Gooder, Will .....	St. Paul, Minn. ....	Aug. 1, 1881	Mar. 16, 1945.
Margolis, David .....	Chicago, Ill. ....	Jan. 3, 1893	Sept. 22, 1919.

## CHILLICOTHE, OHIO

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Ashmore, Maj. Buell L. ....	Hopkins County, Ky. ....	Dec. 4, 1889	Mar. 30, 1927.
Esposito, Capt. Albert C. ....	Pittsburgh, Pa. ....	Nov. 9, 1912	Oct. 16, 1939.
Futrelle, Lt. Col. Walter E. ....	Conway, N. C. ....	Nov. 10, 1886	May 11, 1931.
Halle, Capt. Louis .....	New York City .....	July 28, 1908	Feb. 2, 1942.
Hanus, Capt. Joseph J. ....	Bryan, Tex. ....	Dec. 31, 1898	July 1, 1942.
Hyman, Capt. Barnett M. ....	No record available .....	June 12, 1908	Oct. 1, 1940.
Kravetz, Capt. Irwin .....	Jersey City, N. J. ....	Dec. 19, 1913	Feb. 3, 1941.
Kruglik, Capt. Meyer .....	Brooklyn, N. Y. ....	Nov. 3, 1914	Feb. 2, 1942.
Madden, Maj. Arthur B. ....	New York City .....	Apr. 4, 1894	Feb. 23, 1933.
Sharp, Maj. William T. ....	Kimberly, W. Va. ....	June 29, 1907	Sept. 23, 1937.
Tanner, Capt. Henry .....	New York City .....	Feb. 15, 1904	Sept. 16, 1942.
<b>Civilian medical officer:</b>			
Garrett, Ephraim Spencer, Jr. ....	Mount Willing, Ala. ....	Nov. 3, 1897	June 1, 1943.

## COATESVILLE, PA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Allen, Maj. Adam G. ....	Miamisburg, Ohio .....	Sept. 4, 1908	Nov. 1, 1939.
Horst, Capt. Elmer L. ....	Annaville, Pa. ....	Dec. 2, 1912	Do.
McCullough, Capt. John D. ....	Solomon, Kans. ....	Feb. 17, 1905	Oct. 16, 1941.
Polan, Maj. Simon .....	Philadelphia, Pa. ....	Dec. 24, 1912	Nov. 9, 1939.
Woods, Lt. Col. Leo G. ....	Birmingham, Ala. ....	Oct. 8, 1889	July 1, 1927.
<b>Civilian medical officers:</b>			
Bailey, William .....	Lyndon, Vt. ....	Jan. 29, 1893	Feb. 1, 1944.
Fulmer, Joseph C. ....	Williamsport, Pa. ....	Aug. 22, 1884	Feb. 25, 1921.
Katzman, George M. ....	Ravno, Poland .....	Jan. 1, 1900	Mar. 16, 1942.
Kotzin, Isadore .....	Pennsylvania .....	Apr. 29, 1907	Nov. 1, 1941.
Miller, Clarence R. ....	Pacific, Mo. ....	Jan. 17, 1890	July 19, 1919.
Podall, Harry C. ....	New Haven, Conn. ....	May 22, 1883	July 15, 1921, to June 11, 1925.
<b>Civilian dental officer:</b>			
Neilon, John E. ....	Addison, N. Y. ....	Jan. 18, 1891	Oct. 3, 1921.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## COLUMBIA, S. C.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Alion, Capt. John J.....	Chicago, Ill.....	Nov. 25, 1909	Nov. 1, 1939.
Barnett, Maj. Roy N.....	Woodmere, N. Y.....	June 6, 1914	Aug. 1, 1941.
Burger, Capt. Mortimer D.....	New York, N. Y.....	Dec. 25, 1908	Feb. 3, 1941.
Butt, Capt. William J.....	.....	May 15, 1887	Jan. 1, 1931.
Eaddy, Maj. Albert M.....	Timmons ville, S. C.....	May 18, 1903	Do.
Hartnett, Maj. William C.....	Toledo, Ohio.....	June 2, 1903	July 1, 1942.
Miller, Capt. Harold.....	Brooklyn, N. Y.....	Nov. 12, 1917	Mar. 16, 1942.
Potosky, Capt. Henry.....	New York.....	July 7, 1909	Feb. 17, 1939.
Rosenberg, Maj. Nathan.....	Kansas City, Mo.....	June 30, 1894	Nov. 7, 1938.
Zimmerman, Maj. Solomon L.....	New York City, N. Y.....	Feb. 12, 1912	Dec. 1, 1939.
<b>Civilian medical officers:</b>			
Birch, Louis.....	Warsaw, Poland.....	Dec. 29, 1906	Do.
Cohee, Henry Daniel.....	Ashland, Ga.....	Dec. 20, 1886	May 4, 1925.
Ruoff, John Sebastian.....	Natchez, Miss.....	Aug. 15, 1889	Aug. 1, 1925.
Smarr, Roy G.....	Sharon, S. C.....	Aug. 29, 1909	June 1, 1944.
Woods, Jackson F.....	Irene, S. C.....	Apr. 25, 1896	Mar. 1, 1931.
<b>Commissioned dental officers:</b>			
Richards, Maj. Paul E.....	Eageltown, Ind.....	Aug. 13, 1895	Oct. 19, 1931.
Taylor, Capt. William F.....	.....	July 9, 1895	Dec. 17, 1930.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Fishburne, Skottowe B.....	Williamsburg County, S. C.....	Nov. 27, 1875	June 16, 1922.
Foster, Ralph K.....	Lancaster, S. C.....	May 11, 1884	Jan. 18, 1944.
Hall, Price B.....	Belmont, N. C.....	Apr. 14, 1880	Mar. 2, 1944.

## COLUMBUS, OHIO

<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officer:</b>			
Hendman, Samuel.....	Iberia, Ohio.....	Dec. 23, 1879	Aug. 22, 1921.

## DALLAS, TEX.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Freed, Maj. Harold.....	Lithuania.....	Dec. 28, 1890	Apr. 3, 1924.
Fromm, Capt. Charles S.....	New York, N. Y.....	Apr. 7, 1912	Nov. 1, 1939.
Lipschultz, Capt. Bernard M.....	do.....	Nov. 14, 1912	May 1, 1941.
Magruder, Lt. Col. Charles.....	Monrovia, Md.....	June 23, 1891	Jan. 17, 1925.
Mock, Maj. Ernest L.....	Bluffton, Ind.....	Oct. 9, 1896	Sept. 1, 1936.
Powell, Maj. Homer.....	Brownwood, Tex.....	Oct. 4, 1889	Sept. 18, 1922.
Sazama, Capt. John J., Jr.....	Chicago, Ill.....	Aug. 20, 1911	Jan. 16, 1939.
<b>Civilian medical officers:</b>			
Beckman, Monroe A.....	Oldenburg, Tex.....	Aug. 8, 1888	Nov. 1, 1944.
Karras, Ray.....	No record available.....	Oct. 4, 1888	Dec. 1, 1919.
Patton, Edgar.....	Clay, Miss.....	June 18, 1886	June 16, 1928.
Rowe, Forsythe.....	Hillsboro, Tex.....	Aug. 18, 1893	Sept. 13, 1922.
Standifer, Charles H.....	Bastrop County, Tex.....	Oct. 15, 1882	Aug. 16, 1926.
Stephenson, William O.....	Corinth, Miss.....	July 26, 1873	Feb. 3, 1944.
<b>Commissioned dental officer:</b>			
Powell, Capt. Daron H.....	Eulogy, Tex.....	Aug. 26, 1895	Aug. 21, 1928.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Booth, Carleton.....	Macomb, Ill.....	July 9, 1871	Feb. 11, 1944.
Gooden, Thomas M.....	Stephenville, Tex.....	Nov. 4, 1887	Jan. 2, 1945.
Maxwell, Samuel A.....	Dubuque County, Iow.a.....	Jan. 27, 1872	Mar. 12, 1945.
McBride, James T.....	Belleville, Ill.....	Aug. 2, 1871	Nov. 4, 1943.
Usury, Raleigh S.....	Calhoun County, Ala.....	Feb. 11, 1885	Apr. 1, 1944.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## DANVILLE, ILL.

Name	Place of birth	Date of birth	Date of appointment
MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Cancellieri, Capt. Remo.....	New York, N. Y.....	Nov. 12, 1907	Nov. 2, 1942.
Elledge, Maj. Lloyd C.....	Cincinnati, Ohio.....	Feb. 2, 1898	Sept. 1, 1925.
Klemmer, Maj. Herbert.....	Philadelphia, Pa.....	Jan. 19, 1911	Nov. 1, 1939.
Lipkin, Capt. Sam J.....	Milwaukee, Wis.....	Dec. 28, 1908	Oct. 6, 1938.
Prata, Capt. Michael.....	New York, N. Y.....	Mar. 29, 1903	Jan. 4, 1943.
Rothman, Capt. Harold.....	Brooklyn, N. Y.....	Dec. 27, 1913	Dec. 1, 1941.
Werba, Maj. Daniel R.....	Milwaukee, Wis.....	Dec. 22, 1898	Mar. 16, 1927.
Workman, Capt. Abraham D.....	Brooklyn, N. Y.....	Dec. 30, 1911	Feb. 2, 1942.
Civilian medical officers:			
Rice, Geo. D.....		Aug. 31, 1880	Apr. 7, 1924.
Rowland, George.....	Delaware, Ohio.....	Jan. 17, 1879	July 1, 1919.
Thompson, John J.....	Ontario, Canada.....	Oct. 26, 1879	May 26, 1924.
Commissioned dental officers:			
Abraham, First Lt. Ray T.....	Pittsburgh, Pa.....	Sept. 17, 1906	Mar. 13, 1942.
Burke, Capt. John J.....	St. Louis, Mo.....	Oct. 11, 1888	Nov. 20, 1920.

## DAYTON, OHIO

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Abrahamson, Maj. William.....	No record available.....	Aug. —, 1911	Nov. 1, 1939.
Arduno, Capt. Lino J.....	Centerville, Iowa.....	Dec. 18, 1914	Oct. 16, 1939.
Barnett, Maj. Abner J.....	Carthage, Miss.....	Oct. 21, 1892	May 8, 1931.
Brogan, Maj. Austin J.....	Archibald, Pa.....	Jan. 29, 1905	Jan. 20, 1938.
Brown, Lt. Col. Robert N.....	Johnson City, Tenn.....	June 17, 1903	July 16, 1930.
Burton, Lt. Col. Claud C.....	Louisville, Ky.....	Mar. 24, 1897	July 5, 1921.
Camp, Capt. Walter H.....	Brooklyn, N. Y.....	Oct. 31, 1913	Dec. 2, 1940.
Caruso, Capt. Rocco J.....	Newark, N. J.....	Nov. 27, 1897	Apr. 1, 1942.
Chazin, Capt. Benjamin J.....	Lubav, Russia.....	July 8, 1901	Dec. 1, 1941.
Colangelo, Capt. Cornelius C.....	United States of America.....	Nov. 9, 1915	May 1, 1941.
Davis, Capt. James S.....	Boston, Mass.....	June 22, 1913	Feb. 2, 1942.
Dugdale, Capt. Frederick E.....	Lowell, Mass.....	May 28, 1906	Dec. 1, 1941.
Einhorn, Capt. Harry.....	Brooklyn, N. Y.....	June 11, 1909	Oct. 1, 1940.
De Rago, Capt. Clifford L.....	New York City.....	Nov. 28, 1900	Dec. 29, 1944.
Eisenberg, Capt. Joseph A.....	Milwaukee, Wis.....	Aug. 27, 1908	Jan. 3, 1939.
Garner, Capt. Amos D.....	Paragould, Ark.....	Sept. 22, 1913	June 1, 1942.
Holsinger, Capt. Robert E.....	Washington, Ind.....	Feb. 12, 1906	Mar. 2, 1942.
Nolan, Maj. Don E.....	Beardsley, Minn.....	Sept. 21, 1905	Oct. 5, 1938.
Rhodes, Capt. Marvin P.....	Brooklyn, N. Y.....	Aug. 15, 1911	May 1, 1941.
Robertson, Maj. Robert C.....	Republic, Mo.....	Aug. 6, 1883	Sept. 16, 1925.
Royal, Maj. Warren M.....	Georgia.....	Jan. 7, 1885	Aug. 10, 1924.
Schillinger, Lt. Col. Edward N.....	Covington, Ohio.....	Oct. 6, 1889	May 15, 1919.
Speier, Capt. Aaron S.....	Crete, Nebr.....	Jan. 20, 1898	Mar. 16, 1942.
Stewart, Maj. Edgar A.....	Quincy, Ill.....	May 6, 1881	Apr. 16, 1927.
Thomas, Capt. Maurice C.....	New York City, N. Y.....	Apr. 7, 1902	Mar. 1, 1943.
Zollett, Capt. Phillip B.....	Russia.....	Apr. 10, 1906	May 1, 1941.
Civilian medical officers:			
Brown, Arthur M.....	Cherokee, Iowa.....	Dec. 31, 1881	May 10, 1920.
Gartlitz, Arnold.....	No record available.....	Feb. 15, 1874	Apr. 15, 1928.
Gillam, Anna J.....	Worcester, Mass.....	July 4, 1883	Sept. 1, 1944.
Hynes, Joseph C.....	St. Louis, Mo.....	Dec. 4, 1878	Apr. 17, 1923.
Lockwood, Kenneth L.....	Covington, Ky.....	Jan. 30, 1896	Oct. 16, 1944.
Perkins, Ruffin.....	La Fourche Parish, La.....	Jan. 5, 1880	Nov. 10, 1919.
Reichard, Simon.....	Mauch Chunk, Pa.....	June 8, 1878	June 1, 1921.
Schiffer, Harry.....	Brooklyn, N. Y.....	Sept. 5, 1908	Jan. 4, 1943.
Sullivan, Claude.....	Zebulon, Ga.....	Jan. 6, 1895	Aug. 1, 1923.
Commissioned dental officers:			
Dailey, Lt. Frank L., USNR.....	Larchmont, N. Y.....	May 21, 1887	May 4, 1937.
Linck, Capt. George A.....	Leavenworth, Kans.....	Nov. 24, 1899	Aug. 1, 1930.
Pyfrin, Maj. Sherman A.....	Connorsville, Ind.....	June 25, 1898	Jan. 20, 1924.
Civilian dental officer:			
Fain, Henry G.....	Atlanta, Ga.....	Apr. 14, 1884	June 12, 1929.
ADJUDICATION ACTIVITIES			
Civilian medical officers:			
George, Raymond.....	Woodford, Ill.....	July 4, 1883	Jan. 16, 1930.
Kitsmiller, Clyde A.....	New Albany, Ohio.....	Mar. 5, 1872	Oct. 1, 1943.
Neidhamer, Claude.....	Indianapolis, Ind.....	June 18, 1891	July 1, 1931.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## DEARBORN, MICH.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Caputo, Maj. Joseph M.....	Pittsburgh, Pa.....	June 20, 1906	Sept. 7, 1937.
Fitzporter, Maj. Alonzo L.....	St. Louis, Mo.....	July 23, 1884	May 1, 1931.
Fox, Maj. Morris E.....	Malin, Russia.....	Dec. 22, 1908	Apr. 17, 1939.
Fracasse, Capt. John.....	Pollutri, Italy.....	Nov. 15, 1907	Feb. 1, 1940.
Hunter, Capt. Lawrence M.....	New York City, N. Y.....	June 7, 1905	June 1, 1942.
Kamin, Capt. Louis.....	Slutz, Russia.....	Mar. 16, 1896	Apr. 2, 1933.
Levin, Capt. Myron J.....	Los Angeles, Calif.....	Mar. 6, 1912	Nov. 1, 1939.
Marcus, Maj. Ernest.....	Detroit, Mich.....	July 8, 1909	Jan. 17, 1938.
Nuzzolo, Capt. Charles A.....	Paterson, N. J.....	July 12, 1908	Nov. 2, 1942.
Rothman, Maj. Herman R.....	Pittsburgh, Pa.....	Nov. 25, 1904	Feb. 1, 1934.
Schlusell, Maj. Maurice J.....	Austria.....	July 15, 1907	Dec. 18, 1936.
Varco, Capt. Benedict William.....	Buffalo, N. Y.....	Sept. 26, 1904	Oct. 1, 1940.
Waters, Lt. Col. Pattison A.....	Denver, Colo.....	Nov. 23, 1892	May 1, 1921.
<b>Civilian medical officers:</b>			
Barnes, Van D.....	Fayette, Ohio.....	Mar. 4, 1892	Sept. 16, 1930.
Eakins, Fred J.....	Robards, Ky.....	July 27, 1886	Apr. 1, 1935.
Howell, James A.....	Grant City, Mo.....	Mar. 29, 1892	Aug. 2, 1922.
Makman, Saul H.....	Akron, Ohio.....	Nov. 8, 1898	Feb. 1, 1924.
Smith, Clifton H.....	Underhill, Vt.....	July 6, 1889	Nov. 1, 1919.
<b>Commissioned dental officers:</b>			
Baker, Capt. William J.....	Denver, Colo.....	Mar. 20, 1894	Dec. 17, 1927.
Jacobson, Capt. Clarence R.....	Tracy, Minn.....	Jan. 28, 1894	July 1, 1920.
Pawl, 1st Lt. Earle E.....	Marrissa, Ill.....	Oct. 11, 1887	Nov. 4, 1943.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Hopkins, Samuel R.....	Delavan, Ill.....	Oct. 25, 1876	Oct. 8, 1923.
Troxler, William E.....	Greensboro, N. C.....	June 18, 1895	Nov. 7, 1921.

## DENVER, COLO.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Black, Maj. Walter A.....	Mount Pleasant, Tex.....	Jan. 15, 1888	Jan. 15, 1923.
Breitzer, Capt. Bernard.....	New York City.....	July 26, 1908	Aug. 1, 1938.
Fricke, Capt. Fred J.....	Aloe City, Nebr.....	Nov. 23, 1906	Mar. 27, 1936.
Rosenberg, 1st Lt. Saul.....	Brooklyn, N. Y.....	Feb. 18, 1912	Nov. 30, 1943.
<b>Civilian medical officers:</b>			
Partington, Cyrus.....	Fall River, Mass.....	Dec. 12, 1889	May 1, 1920.
<b>Commissioned dental officers:</b>			
Lomax, Capt. Clifford C.....	Bristow, Ind.....	Oct. 16, 1892	Apr. 8, 1921.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian Medical officers:</b>			
Boe, Roy A.....	Soldier, Iowa.....	Nov. 25, 1900	Nov. 4, 1940.

## DES MOINES, IOWA

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Bielinski, Capt. Stefan.....	Chicago, Ill.....	Apr. 17, 1913	Aug. 1, 1941.
Bogan, Lt. Col. Robert J.....	Utica, N. Y.....	Sept. 16, 1898	Sept. 4, 1930.
Carrow, Capt. Roland A.....	Goodrich, Ill.....	Feb. 18, 1900	Mar. 16, 1942.
Everist, Maj. Guy V.....	Marshalltown, Iowa.....	Aug. 30, 1908	June 22, 1937.
Frien, Capt. James J.....	New York, N. Y.....	Jan. 16, 1914	June 15, 1942.
Hoffman, Maj. Clifford W.....	Laurel, Ind.....	Oct. 3, 1896	June 17, 1940.
Miller, Maj. Dwight F.....	Portland, Oreg.....	Mar. 12, 1888	Feb. 18, 1938.
Peck, Maj. Hyman.....	New York, N. Y.....	Feb. 12, 1908	Jan. 15, 1940.
Samberg, Capt. Harry H.....	do.....	Sept. 30, 1904	Feb. 3, 1941.
Wollenman, Maj. Max Joseph.....	Ferdinand, Ind.....	May 30, 1901	Aug. 5, 1930.
<b>Civilian dental officers:</b>			
Clark, Burton.....	Sheridan, Mo.....	Mar. 19, 1877	Jan. 1, 1928.
Drysdale, William T.....	Punjab, India.....	July 27, 1882	Jan. 1, 1931.
Larimore, Ogil T.....	Clifton, Kans.....	Feb. 27, 1894	Feb. 12, 1930.
Nadig, Clyde M.....	Elizabeth, Ill.....	June 9, 1905	Oct. 1, 1940.
<b>Civilian dental officers:</b>			
Akin, Hamilton L.....	Chicago, Ill.....	July 11, 1896	Nov. 15, 1943.
Baldwin, John W.....	Le Raysville, Tenn.....	Nov. 21, 1888	July 23, 1928.



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## DES MOINES, IOWA—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>ADJUDICATION ACTIVITIES</b>			
Commissioned medical officer:			
Corbin, Capt. Ray L.....	Norway, Iowa.....	Oct. 17, 1897	Jan. 1, 1944.
Civilian medical officers:			
Brown, Harry W.....	Waterloo, Iowa.....	Aug. 9, 1880	Mar. 16, 1944.
Trotter, William.....	Eddyville, Iowa.....	Sept. 17, 1880	Oct. 9, 1944.

## DOWNEY, ILL.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Benson, Maj. George B.....	Richland Center, Wis.....	Sept. 14, 1902	July 8, 1940.
Delong, Maj. Edward E.....	Chicago, Ill.....	Dec. 9, 1909	Feb. 9, 1939.
Gallo, Capt. William C.....	New York, N. Y.....	July 16, 1913	Aug. 1, 1941.
Golob, Capt. Meyer E.....	Brooklyn, N. Y.....	Jan. 2, 1912	Dec. 2, 1940.
Goode, Col. Delmar.....	Myrtle, Miss.....	Feb. 17, 1889	June 21, 1923.
Green, Maj. John W.....	West, Miss.....	Mar. 28, 1889	Jan. 19, 1931.
Mason, Maj. Aaron S.....	Russia.....	Mar. 3, 1911	Nov. 3, 1938.
Rodriguez, Lt. Col. Antonio.....	Puerto Rico.....	Dec. 22, 1893	Apr. 17, 1919.
Simonson, Capt. Melvin.....	Chicago, Ill.....	Jan. 21, 1914	Aug. 1, 1941.
Wood, Maj. Lorin F., Jr.....	East Hampton, Conn.....	Mar. 3, 1885	June 1, 1925.
Civilian medical officers:			
Erps, Benjamin.....	Hungary.....	Apr. 15, 1902	Dec. 15, 1930.
Roble, Andrew.....	Manferd, N. Dak.....	June 30, 1896	Mar. 1, 1945.
Civilian dental officers:			
Cressey, William.....	Louisville, Ky.....	May 24, 1880	July 20, 1926.
Feldman, Benjamin L.....	Chicago, Ill.....	July 1, 1909	June 1, 1942.

## DWIGHT ILL.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Crowell, Maj. Marvin.....	Scotland, Ark.....	Sept. 27, 1896	Oct. 3, 1935.
Harvey, Capt. Salmon C.....	New York City, N. Y.....	Nov. 14, 1909	Aug. 1, 1941.
Kendall, Lt. Col. William E.....	Mason City, Ill.....	Mar. 17, 1884	Sept. 4, 1929.
Knudson, Maj. Alvin B. C.....	Waubay, S. Dak.....	June 28, 1910	Nov. 1, 1939.
Raich, Maj. John A.....	Kansas City, Mo.....	Mar. 16, 1901	Aug. 8, 1935.
Schmerer, Capt. Frederick.....	New York City, N. Y.....	Dec. 22, 1912	Aug. 1, 1941.
Civilian medical officer:			
Taylor, Septimus Theodore.....	South Carolton, Ky.....	June 1, 1879	Dec. 1, 1920.
Commissioned dental officer:			
Durkee, Capt. Eugene W.....	Milwaukee, Wis.....	Jan. 7, 1896	May 24, 1937.

## EXCELSIOR SPRINGS, MO.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Altomare, Capt. Edward P.....	New York City, N. Y.....	Dec. 23, 1911	Mar. 16, 1942.
Bell, Lt. Col. Forrest G.....	Illinois.....	Feb. 28, 1892	May 26, 1936.
Glasser, Capt. Joseph.....	Warsaw, Poland.....	July 1, 1910	May 1, 1941.
Glasser, Maj. Seymour.....	New York, N. Y.....	May 27, 1909	Jan. 20, 1939.
Keller, Capt. Louis.....	New York, N. Y.....	July 25, 1906	Nov. 1, 1939.
Kozinn, Capt. Philip J.....	Poland.....	Sept. 6, 1912	Nov. 2, 1942.
Mantell, Maj. Francis J.....	Laurel, Miss.....	Mar. 2, 1903	July 19, 1930.
Netzer, Maj. Solomon.....	New York, N. Y.....	Sept. 22, 1900	Mar. 16, 1942.
Schaff, Maj. Burnett.....	New Haven, Conn.....	May 14, 1908	Dec. 2, 1940.
Tapp, Lt. Col. Ernest M.....	West Mansfield, Ohio.....	May 28, 1904	Dec. 3, 1931.
Tripodi, Maj. Donald W.....	Italy.....	Nov. 14, 1894	Sept. 16, 1940.
Civilian dental officer:			
Adams, Leo J.....	Bainesville, Ohio.....	Feb. 28, 1892	Jan. 15, 1923.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## FARGO, N. DAK.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Diamond, Capt. Jack L. ....	Brooklyn, N. Y. ....	Sept. 2, 1909	Sept. 1, 1938.
Einterz, Capt. George F. ....	New York City, N. Y. ....	June 2, 1914	Feb. 3, 1941.
Herman, Maj. Lester R. ....	Conde, S. Dak. ....	Mar. 18, 1891	Dec. 11, 1930.
Manaugh, Maj. Hursel C. ....	Lexington, Ind. ....	Dec. 13, 1899	Jan. 4, 1932.
Rosen, Capt. Michael. ....	New York City, N. Y. ....	Jan. 12, 1905	Mar. 12, 1936.
Smith, Lt. Col. Clifton H. ....	Underhill, Vt. ....	July 6, 1885	Nov. 1, 1919.
Tyson, Maj. John J. ....	Ayden, N. C. ....	Oct. 12, 1891	Sept. 18, 1934.
<b>Commissioned dental officer:</b>			
Hauser, Capt. Walter C. ....	Anaconda, Mont. ....	July 10, 1895	Sept. 24, 1931.

## FAYETTEVILLE, ARK.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Kaufman, Capt. Benjamin M. ....	Manhattan, N. Y. ....	July 7, 1912	Aug. 1, 1941.
Kleinman, Maj. Aaron H. ....	New York, N. Y. ....	Feb. 12, 1908	Jan. 16, 1939.
Levine, Capt. Daniel I. ....	New York City, N. Y. ....	Jan. 26, 1911	Mar. 16, 1942.
Leming, Capt. Howell E. ....	Dardanelle, Ark. ....	Jan. 16, 1900	Sept. 16, 1929.
Tompkins, Lt. Col. Raymond D. ....	Lewiston, Ill. ....	Jan. 3, 1884	June 13, 1921.
Wolkin, Capt. Abraham. ....	Newark, N. J. ....	Oct. 18, 1909	Oct. 1, 1940.
<b>Civilian medical officers:</b>			
Delaney, Joseph P. ....	Green Bay, Wis. ....	May 24, 1887	Aug. 1, 1930.
Gordon, Frank N. ....	Savannah, Ga. ....	Apr. 12, 1879	Jan. 1, 1920.
Shafer, Frank N. ....	No record available. ....	Dec. 3, 1876	Sept. 1, 1926.
<b>Civilian dental officer:</b>			
Knox, Frank D. ....	Hannibal, Mo. ....	May 19, 1893	Jan. 15, 1921.

## FAYETTEVILLE, N. C.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Baird, Maj. John A. ....	Fusen, Korea. ....	Oct. 12, 1894	Sept. 1, 1931.
Ebel, Capt. Alfred. ....	Austria. ....	Apr. 5, 1907	July 8, 1940.
Hoot, Maj. Melvin P. ....	Arkansas City, Kans. ....	May 7, 1909	Dec. 2, 1941.
Scott, Maj. Thomas G. ....	Norwood, Ohio. ....	Oct. 2, 1897	Mar. 13, 1939.
Selikoff, Capt. Solomon J. ....	Kiev, Russia. ....	Mar. 12, 1911	Dec. 1, 1939.
Stein, Capt. Elias. ....	New York City, N. Y. ....	Aug. 16, 1910	Dec. 5, 1940.
Walker, Lt. Col. Starnes E. ....	Milan, Tenn. ....	Mar. 15, 1887	May 15, 1921.
<b>Civilian medical officers:</b>			
Corbett, Lacy W. ....	Bishopville, S. C. ....	Feb. 12, 1890	Jan. 2, 1931.
Everett, Jesse J. ....	Resaca, Ga. ....	Sept. 4, 1880	Sept. 27, 1922 to Dec. 30, 1922; Mar. 30, 1925.
Moore, Baxter S. ....	Chester, S. C. ....	Feb. 18, 1879	Oct. 1, 1928.
Rachlin, Stanton A. ....	Brooklyn, N. Y. ....	July 29, 1907	July 7, 1936.
Turner, John W. ....	Milwaukee, Wis. ....	June 21, 1880	Dec. 16, 1919.
Weirick, Albert J. ....	Marseilles, Ill. ....	Dec. 19, 1877	Mar. 16, 1922 to Jan. 31, 1927; May 1, 1931.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officer:</b>			
Lazenby, Earl K. ....	Thompson, Ga. ....	Sept. 25, 1886	Oct. 10, 1929.

## FORT BAYARD, N. MEX.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Crays, Capt. William H. ....	Loogootee, Ind. ....	Nov. 14, 1906	Nov. 1, 1939.
Keeler, Maj. Charles C. ....	Oskaloosa, Iowa. ....	Sept. 2, 1882	Mar. 2, 1924.
Klein, Capt. Harold. ....	Brooklyn, N. Y. ....	June 25, 1910	June 5, 1941.
Lazar, Maj. Harry. ....	Chicago, Ill. ....	Nov. 5, 1908	Oct. 10, 1938.
Marby, Capt. George W. ....	Torre Haute, Ind. ....	May 27, 1914	June 15, 1942.
Nalty, Lt. Col. Walter C. ....	Paola, Kans. ....	Feb. 20, 1899	Aug. 13, 1929.
Walker, Lt. Col. Albert G. ....	Thomaston, Maine. ....	Feb. 4, 1883	Mar. 10, 1920.
Zausner, Maj. Joseph. ....	New York, N. Y. ....	Feb. 27, 1910	Sept. 16, 1941.
<b>Commissioned dental officers:</b>			
Morene, Capt. Albert. ....	Portland, Oreg. ....	Nov. 11, 1897	Oct. 15, 1935.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## FORT CUSTER, MICH.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Baden, Capt. David D.	Cleveland, Ohio	Mar. 18, 1898	Apr. 1, 1944.
Herman, Capt. Louis	New York, N. Y.	Dec. 15, 1907	May 1, 1941.
Maniscalco, Capt. Anthony E.	Brooklyn, N. Y.	Apr. 4, 1911	Sept. 16, 1942.
Nunez, Capt. Edgar O.	Grenada, British West Indies	Dec. 17, 1903	June 1, 1942.
Olsen, Maj. Albert L.	Richfield, Utah	Oct. 12, 1904	Apr. 1, 1938.
Orr, Maj. Eli H.	Mount Erie, Ill.	May 1, 1898	Mar. 2, 1931.
Schwarz, Maj. Frank W.	Philadelphia, Pa.	Feb. 21, 1887	Jan. 16, 1923.
Toms, Lt. Col. Roland E.	Williamston, Mich.	Nov. 9, 1889	Apr. 1, 1921.
Weintraub, Capt. Arthur	Odessa, Russia	May 21, 1907	Dec. 1, 1941.
<b>Civilian medical officer:</b>			
Hentz, Roger P.	Courtland, Miss.	Dec. 30, 1884	Dec. 15, 1921.
<b>Commissioned dental officer:</b>			
Lundblad, 1st Lt. Clarence H.	St. Paul, Minn.	May 18, 1893	Sept. 16, 1943.
<b>Civilian dental officer:</b>			
Stevens, Edward	Duluth, Minn.	Sept. 16, 1891	July 24, 1940.

## FORT HARRISON, MONT.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Faust, Capt. Joseph M.	Pittsburgh, Pa.	Dec. 19, 1913	Nov. 1, 1939.
Fitzgibbons, Capt. Thomas G.	Sioux Falls, S. Dak.	Jan. 10, 1895	June 1, 1942.
Gier, Capt. Jacob B.	Russia	Jan. 10, 1903	Oct. 21, 1935.
Harmon, Maj. George A.	Rigby, route No. 1, Idaho	Aug. 3, 1897	Dec. 7, 1937.
Hines, Maj. Ralph E.	Leavenworth, Kans.	Dec. 16, 1910	Nov. 1, 1939.
Perkins, Maj. John N.	No record available	Feb. 13, 1892	Jan. 15, 1923.
White, Maj. William E.	do	Mar. 9, 1888	Jan. 6, 1925.
<b>Civilian medical officer:</b>			
Tremblay, Julian L.	Marlboro, Mass.	June 29, 1884	June 3, 1935.
<b>Commissioned dental officer:</b>			
Jones, Capt. Guy H.	Stewart, Minn.	Nov. 3, 1886	June 20, 1931.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officer:</b>			
Fortin, William H.	Chicago, Ill.	Jan. 13, 1880	Feb. 1, 1923.

## FORT HOWARD, MD.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Balter, Lt. Col. Abraham M.	Vilna, Poland	Nov. 12, 1908	May 12, 1931.
Brackin, Capt. John T., Jr.	Lanstowne, Pa.	Jan. 1, 1910	Nov. 16, 1942.
Cullison, Maj. Robert M.	Monteguma, Iowa	Nov. 2, 1891	Nov. 16, 1937.
Fleck, Lt. Col. Warren LeRoy	Neola, Iowa	Feb. 28, 1889	Aug. 30, 1924.
Hurwitz, Capt. Abraham B.	Baltimore, Md.	Apr. 4, 1910	Dec. 2, 1940.
Ochs, Capt. Irving L.	Syracuse, N. Y.	Dec. 1, 1913	Aug. 1, 1941.
Richards, Maj. Hyrum Y.	Perry, Utah	Aug. 5, 1886	Sept. 28, 1931.
Roberts, Capt. David A.	Morganfield, Ky.	Sept. 30, 1903	Mar. 17, 1936.
Ryan, Maj. Francis J.	Hartford, Conn.	May 24, 1909	Mar. 18, 1939.
Zuravin, Capt. Meyer H.	Brooklyn, N. Y.	Oct. 20, 1907	Mar. 1, 1943.
<b>Commissioned dental officer:</b>			
Eastman, Capt. James B.	Winchester, Ind.	Nov. 24, 1890	July 29, 1920.
Rosser, 1st Lt. Eli B.	Edwardsville, Pa.	May 22, 1894	May 24, 1944.
<b>Civilian medical officer:</b>			
Mason, Frank E.	Easton, Md.	Feb. 18, 1893	Sept. 1, 1920.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## FORT LYON, COLO.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Chat, Capt. Emanuel.....	Philadelphia, Pa.....	Oct. 13, 1909	July 16, 1942.
Jackson, Maj. Benjamin F.....	Ozark, Ala.....	Dec. 23, 1899	Oct. 6, 1930.
Mace, Maj. Norman C.....	Portland, Oreg.....	June 8, 1902	Apr. 18, 1931.
Shrout, Col. Cecil B.....	Bunton, Mo.....	Oct. 31, 1891	May 1, 1920.
Weinstock, Capt. Adolph.....	Philadelphia, Pa.....	Dec. 24, 1913	May 1, 1941.
Wharton, Maj. Russell S.....	Marysville, Ohio.....	Sept. 15, 1894	Sept. 4, 1931.
<b>Civilian medical officer:</b>			
Kimball, Isham.....	Jackson, Ala.....	Oct. 27, 1884	Oct. 11, 1944.
<b>Civilian dental officer:</b>			
Gradoville, Charles M.....	Plattsmouth, Nebr.....	Dec. 8, 1895	Dec. 1, 1931.

## FORT MEADE, S. DAK.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Fox, Capt. Thomas H.....	Brooklyn, N. Y.....	May 12, 1907	Oct. 27, 1937.
Kaney, Capt. Emil M.....	Kiev, Russia.....	May 22, 1906	June 15, 1942.
Lewis, Maj. Claud.....	Bible Grove, Ill.....	Mar. 27, 1898	Feb. 17, 1931.
McLin, Lt. Col. Thomas G.....	Fairfield, Ill.....	Apr. 17, 1882	Oct. 25, 1924.
Peffer, Peter A.....	Louisville, Ky.....	Apr. 3, 1902	Mar. 6, 1945.
<b>Civilian medical officer:</b>			
Olson, William E.....	Sioux City, Iowa.....	June 17, 1903	Feb. 3, 1941.
<b>Commissioned dental officer:</b>			
Marsh, Capt. Robert E.....	Bellingham, Wash.....	Feb. 28, 1907	Mar. 1, 1941.

## FORT WASHINGTON, MD.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Smart, Maj. James.....	Chesterfield, Va.....	July 10, 1893	Jan. 21, 1926.
Werner, Capt. Merrill J.....	Golconda, Ill.....	Mar. 26, 1904	Feb. 23, 1938.
<b>Civilian medical officer:</b>			
Benson, Charles Prue.....	Woollers Rest, S. C.....	Apr. 1, 1879	Mar. 16, 1931.

## GULFPORT, MISS.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Dunn, Capt. Maurice.....	Zitomir, Russia.....	Dec. 9, 1910	Oct. 16, 1939.
Holes, Maj. Robert.....	Austria.....	May 24, 1883	Dec. 17, 1934.
Hughes, Maj. James A.....	Jearoldtown, Tenn.....	Sept. 16, 1901	June 18, 1935.
Miller, Maj. Saul D.....	New York, N. Y.....	Oct. 28, 1906	May 1, 1941.
Sheffield, Col. Gettis T.....	Dorsey, Miss.....	Jan. 1, 1883	Mar. 1, 1927.
Winick, Maj. William.....	New Castle, Pa.....	July 15, 1904	July 1, 1938.
Wright, Lt. Col. Frederick L.....	Stanford, Ontario.....	Dec. 7, 1883	Nov. 1, 1920.
<b>Civilian medical officers:</b>			
Davidian, Hagop.....	Afion-Karahissar, Asia Minor.....	Aug. 5, 1877	July 17, 1925, to Jan. 15, 1926; Aug. 11, 1926.
Suraci, Francis X.....	Washington, D. C.....	Sept. 18, 1902	Aug. 8, 1930, to Apr. 3, 1940; Nov. 1, 1943.
<b>Commissioned dental officer:</b>			
Grau, Capt. Adolph E.....	No record available.....	Jan. 29, 1884	Aug. 14, 1922.

## HINES, ILL.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Alexander, Capt. Howard G.....	Snyder, Tex.....	Mar. 4, 1907	Sept. 30, 1938.
Andrew, Maj. Lloyd Brumund.....	Table Rock, Nebr.....	Sept. 7, 1896	Jan. 19, 1937.
Baker, Lt. Col. Lyle A.....	Greenfield, Iowa.....	Sept. 13, 1904	Dec. 12, 1931.
Baumrucker, Capt. George O.....	No record available.....	July 3, 1905	Dec. 20, 1943.
Burstein, Capt. Harry.....	New York City, N. Y.....	July 11, 1909	Mar. 2, 1942.
Bush, Capt. Mitchell W.....	Brooklyn, N. Y.....	Dec. 8, 1909	Sept. 16, 1942.
Caffee, Col. William M.....	Marion, Ala.....	Feb. 23, 1890	Dec. 27, 1944.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## HINES, ILL.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
<b>Commissioned medical officers—Con.</b>			
Colton, Col. Warren A.	Vernal, Utah	Mar. 29, 1883	Mar. 17, 1923.
Fershing, Maj. Jennings	New York City, N. Y.	Dec. 5, 1914	June 15, 1942.
Frankel, Maj. Joseph J.	Philadelphia, Pa.	Aug. 4, 1912	Nov. 1, 1939.
Freeman, Maj. Bromley S.	New York City, N. Y.	May 23, 1912	Jan. 16, 1939.
Givner, Capt. David	Baltimore, Md.	June 1, 1903	Mar. 17, 1941.
Greenberg, Capt. Arthur	Brooklyn, N. Y.	Apr. 22, 1913	Sept. 16, 1942.
Grossman, Capt. Maurice O.	Chicago, Ill.	Mar. 17, 1910	Apr. 1, 1942.
Iger, First Lt. Mortimer	Bronx, N. Y.		Nov. 15, 1943.
Kesert, Maj. Benjamin H.		Jan. 7, 1904	Nov. 28, 1930.
Kline, Capt. Philip S.	Guadalajara, Mexico	Aug. 19, 1910	Aug. 2, 1941.
Kooperman, Capt. Myer	Chicago, Ill.	Nov. 2, 1911	Feb. 3, 1941.
Kulvin, Maj. Max M.	do	Aug. 15, 1891	Feb. 11, 1931.
Lane, Maj. John T.	San Antonio, Tex.	Dec. 11, 1911	Jan. 18, 1939.
Lipson, Maj. Henry I.	Brooklyn, N. Y.	July 29, 1908	Oct. 3, 1938.
McClanahan, Lt. Col. Charles W.		Sept. 9, 1891	May 16, 1924.
McCue, Capt. Daniel J.	Buffalo, N. Y.	Aug. 26, 1915	Sept. 16, 1942.
McNamara, Lt. Col. William L.	Vienna, S. Dak.	Nov. 23, 1898	Sept. 23, 1930.
Mednick, Capt. Edward D.	New York, N. Y.	Apr. 17, 1914	June 15, 1942.
Mitchell, Capt. Holland C.	New York City, N. Y.	Oct. 7, 1906	Feb. 13, 1941.
Musgrave, Capt. David E.	Seattle, Wash.	July 25, 1908	Aug. 1, 1941.
Phillips, Maj. Roy	Cincinnati, Ohio	Feb. 2, 1891	Jan. 30, 1931.
Quamme, Capt. Roy K.	Bottineau, N. Dak.	June 21, 1905	Aug. 1, 1941.
Quenzer, Capt. Fred August	Chicago, Ill.	May 29, 1912	Jan. 3, 1939.
Sackadorf, Capt. Harry	New York, N. Y.	Aug. 21, 1906	Mar. 16, 1942.
Schrek, Maj. Robert	do	Dec. 28, 1907	Nov. 4, 1937.
Silver, Capt. Saul I.	do	Oct. 2, 1909	Jan. 15, 1910.
Slobodin, Maj. Harry	do	Feb. 7, 1909	May 17, 1937.
Stephenson, Capt. Hack U. Jr.	Toano, Va.	Dec. 19, 1909	July 26, 1937.
Stevens, Capt. Ernest J.	Santa Rosa, Calif.	Dec. 14, 1915	Sept. 16, 1942.
Thomas, Maj. Ralph A.	Traer, Kans.	Aug. 8, 1903	Jan. 24, 1938.
Timberlake, Lt. Col. Harold P.	Demos, Ohio	Jan. 6, 1891	Mar. 1, 1920.
Trauba, Lt. Col. Norbert C.	Marathon, Wis.	Apr. 20, 1898	Sept. 1, 1928.
<b>Civilian medical officers:</b>			
Allaben, Gerald R.	Argyle, Ill.	July 9, 1889	1922 to 1923; Feb. 1, 1932.
Cefai, Anthony F.	Malta (Europe)	Oct. 26, 1907	June 1, 1943.
Costich, Kenneth J.	Rochester, N. Y.	Feb. 29, 1912	Sept. 26, 1933.
Feldott, Harry R.	Batavia, Ill.	Feb. 1, 1895	July 14, 1919.
Fitzsimmons, Joseph I.	Clinton, Iowa	Dec. 10, 1898	Sept. 23, 1930.
Flynn, John F.	Chicago, Ill.	Mar. 17, 1895	June 9, 1928.
Frow, James R.	Lewiston, Pa.	June 2, 1883	Aug. 14, 1928.
Punkhouser, Ralph M.	Indiana	Aug. 14, 1884	June 11, 1921.
Gburezyk, Frank H.	Joliet, Ill.	Jan. 19, 1894	Sept. 8, 1920.
Graham, Albert P.	Early, Iowa	Jan. 2, 1905	Jan. 10, 1938.
Haefner, Albert W.	Knoxville, Iowa	Nov. 7, 1881	Aug. 16, 1944.
Hemminger, John R.	Somerset, Pa.	Oct. 7, 1875	Aug. 16, 1944.
Kipnis, Harry	Russia (naturalized)	Dec. 17, 1905	May 4, 1931.
Williams, Albert	Madelay, England	Mar. 15, 1881	Aug. 1, 1927.
Krasner, Leonard	Newark, N. J.	June 15, 1908	Oct. 1, 1940.
Lenowitz, Herman	Russia	Mar. 4, 1897	Dec. 8, 1939.
Judwig, Dorothy B.	Cernauti, Rumania	Nov. 16, 1909	Aug. 16, 1944.
Maloy, Bernard S.	Rensselaer, Ind.	Jan. 3, 1874	Sept. 11, 1944.
Ogden, Claude H.	Cedarville, N. J.	Oct. 21, 1890	Apr. 1, 1944.
Randolph, Henry E.	Raun, Ill.	May 2, 1883	Jan. 2, 1923.
Rowe, Lee B.	Broadhead, Wis.	Dec. 18, 1883	Sept. 18, 1944.
Rushton, James S.	No record available	Aug. 2, 1879	Oct. 15, 1924.
Russell, James	Chicago, Ill.	Nov. 16, 1898	Mar. 16, 1942.
Shamaskin, Arnold	Russia	Aug. 22, 1881	June 26, 1940.
Sherlock, William P.	Des Moines, Iowa	Apr. 30, 1884	Jan. 7, 1920.
Sodard, Anthony	Italy	Mar. 17, 1884	June 19, 1944.
Ward, Benjamin F.	Inez, Ky.	June 29, 1891	June 20, 1919.
Weinstein, Bernard	Norwalk, Conn.	Feb. 22, 1914	Feb. 2, 1942.
Zolla, Norman	Russia	Oct. 5, 1888	Jan. 24, 1944.
<b>Commissioned dental officers:</b>			
Lister, Maj. Clarence S.	Manchester, Iowa	Oct. 8, 1881	Feb. 16, 1920.
Logsdon, Maj. Cale M.	Jinks, Ky.	Nov. 2, 1896	Mar. 1, 1932.
Swift, Maj. Lionel V.	Stanton, Tex.	Jan. 18, 1896	Dec. 15, 1922.
<b>Civilian dental officers:</b>			
Cheely, Walter C.	Denver, Colo.	May 31, 1884	Nov. 4, 1919.
Rohner, Joseph J.	No record available	Nov. 2, 1888	Feb. 2, 1931.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Commissioned medical officers:</b>			
Bedessem, Lt. Col. Philip M.	Chicago, Ill.	Apr. 5, 1891	Apr. 23, 1920.
Wilson, Capt. Nilas M.	Montgomery, Ind.	Dec. 10, 1888	Feb. 9, 1942.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## HINES, ILL.—Continued

Name	Place of birth	Date of birth	Date of appointment
ADJUDICATION ACTIVITIES—Con.			
Civilian medical officers:			
Blau, James W.....	Fountain Green, Ill.....	Mar. 19, 1881	Apr. 6, 1944.
Brown, Paul F.....	Lake City, Minn.....	Oct. 19, 1877	Dec. 1, 1919.
Danielson, Wilford.....	Osceola, Nebr.....	Dec. 20, 1891	1921 to 1926; Sept. 20, 1943.
Dowiat, Stanley A.....	Chicago, Ill.....	Aug. 2, 1901	Feb. 1, 1944.
Doyle, Nicholas M.....	Caledonia, Ontario.....	Feb. 2, 1880	Jan. 18, 1944.
Goy, Michael Charles.....	Poland (naturalized).....	Sept. 20, 1884	Jan. 24, 1944.
Hurka, Robert.....	Cedar Rapids, Iowa.....	May 1, 1887	Nov. 22, 1920.
Karg, Frank.....	Kalomya, Poland.....	Jan. 29, 1906	May 1, 1944.
O'Neil, Dillan G.....	Elgin, Ill.....	June 11, 1886	Feb. 14, 1944.
Pedott, Meyer S.....	Russia.....	May 28, 1887	Jan. 17, 1944.
Rategan, Edward H.....	Chicago, Ill.....	Apr. 21, 1891	Apr. 1, 1944.
Roberts, Sidney M.....	do.....	Oct. 3, 1887	Do.
Romano, John R.....	Italy.....	July 10, 1888	Jan. 18, 1944.
Stollenwerk, R. J.....	Milwaukee, Wis.....	Aug. 3, 1907	Nov. 1, 1943.

## HOT SPRINGS, S. DAK.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Campanella, Capt. Santo D.....	New York, N. Y.....	Sept. 26, 1908	Nov. 1, 1939.
Cramer, Maj. Lloyd L.....	Omaha, Nebr.....	Jan. 13, 1886	Dec. 7, 1929.
Jewett, Lt. Comdr. Geo. Rae.....	Wabash, Ind.....	Dec. 1, 1897	Apr. 24, 1935.
Levin, Maj. Louis.....	Wilma, Russia.....	Oct. 29, 1903	Oct. 1, 1940.
Miller, Capt. George A.....	St. George, W. Va.....	July 20, 1907	Jan. 15, 1940.
Ogg, Lt. Col. Francis W.....	Douglass, Kans.....	May 30, 1894	Aug. 23, 1943.
Schneider, Capt. Martin.....	New York, N. Y.....	Apr. 15, 1913	Feb. 1, 1940.
Welty, Capt. Dalton M.....	Hagerstown, Md.....	June 26, 1913	July 16, 1942.
Civilian medical officer:			
Raibourn, Richard.....	Linnville, Ind.....	Sept. 26, 1877	Mar. 30, 1920.
Commissioned dental officer:			
Hanlon, Capt. John P.....	Cherokee, Iowa.....	July 20, 1906	Nov. 12, 1938.
Civilian dental officer:			
Roberts, Floyd J.....	Rockford, Minn.....	July 14, 1876	Mar. 1, 1929.

## HUNTINGTON, W. VA.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Blotner, Maj. Carl.....	Salem, N. H.....	Dec. 30, 1906	Oct. 6, 1938.
Dodson, Capt. Ross.....	Glenville, W. Va.....	Apr. 11, 1883	Nov. 12, 1921.
Levine, Capt. Morris H.....	Lowell, Mass.....	Nov. 4, 1905	July 8, 1940.
Mertz, Capt. Philip.....	Dupont, Pa.....	Jan. 2, 1910	July 16, 1942.
Pearlman, Capt. Carl Kenneth.....	Brooklyn, N. Y.....	Aug. 18, 1908	May 1, 1941.
Schnitt, Capt. Sidney.....	New York, N. Y.....	Feb. 28, 1914	Oct. 1, 1940.
Walsh, Capt. Eugene L. B.....	Hawkeye, Iowa.....	Sept. 21, 1906	Jan. 17, 1938.
Wiesenfeld, Capt. Benjamin.....	New York, NY.....	Aug. 14, 1910	Nov. 2, 1942.
Civilian medical officers:			
Copeland, Paul Richard.....	Ozark, Ill.....	May 28, 1894	Oct. 10, 1920.
Gellman, Irving I.....	Odessa, Russia.....	Feb. 14, 1890	Jan. 5, 1925.
Sasser, Thomas J.....	Woodcliff, Ga.....	Mar. 27, 1898	May 11, 1937.
Willis, Carson.....	Bridgeport, W. Va.....	Feb. 24, 1878	Nov. 5, 1921.
Commissioned dental officer:			
Timken, First Lt. William H.....	Rush Co., Kans.....	Oct. 11, 1895	Aug. 19, 1942.
Civilian dental officer:			
Whitaker, Lee W.....	Olive Branch, La.....	Nov. 11, 1889	Nov. 27, 1922.
ADJUDICATION ACTIVITIES			
Civilian medical officer:			
Moorman, Earl.....	Hardinsburg, Ky.....	Nov. 11, 1881	Nov. 12, 1925.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## INDIANAPOLIS, IND.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Adams, Maj. Donald R.	Albion, Nebr.	Nov. 23, 1909	Nov. 1, 1939.
Bown, Maj. Albert J.	Peoria, Ill.	Aug. 1, 1898	Sept. 4, 1929.
Choate, Maj. Alton J.	No record	Jan. 15, 1883	Oct. 1, 1921.
Finot, Maj. Philip H.	St. Louis, Mo.	July 17, 1882	July 1, 1919.
Hare, Lt. Col. Earl Hazelton	Sheridan, Ind.	Aug. 26, 1890	June 5, 1922.
Harmon, Capt. Jules	No record	Dec. 18, 1910	Dec. 2, 1940.
Nowack, Capt. Henry J.	Chicago, Ill.	July 28, 1913	Nov. 1, 1939.
Plotkin, Capt. Oscar M.	do	May 26, 1912	Sept. 20, 1938.
Riley, Maj. William J.	do	Oct. 13, 1890	June 17, 1935.
Sales, Capt. Louis M.	New York, N. Y.	Sept. 30, 1910	Nov. 2, 1939.
Tremor, Lt. Col. Victor F.	Owensville, Ind.	Oct. 25, 1895	Feb. 29, 1930.
Unger, Capt. Abraham	New York, N. Y.	Oct. 24, 1911	May 1, 1941.
Warshaw, Capt. Arthur H.	Kansas City, Mo.	Sept. 29, 1906	Mar. 10, 1942.
<b>Civilian medical officer:</b>			
Holwig, Edward C.	Indianapolis, Ind.	Nov. 15, 1884	Oct. 21, 1929.
<b>Commissioned dental officer:</b>			
Toline, Capt. Clarence A.	No record available.	Mar. 20, 1896	Jan. 26, 1932.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Wardel, Frederick	Hagerstown, Ind.	Dec. 6, 1879	Apr. 3, 1944.
Little, Edward O.	Cicero, Ind.	Jan. 27, 1878	June 11, 1919.
Ullrich, Arlie J.	Aurora, Ind.	July 28, 1890	May 11, 1921.

## JACKSON, MISS.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Civilian medical officers:</b>			
Spear, Ross C.	Furman, Ala.	Aug. 11, 1884	Dec. 7, 1919.
Wallace, James M.	No record available.	Apr. 10, 1878	Aug. 15, 1922.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Kahn, Alfred M.	Jackson, Miss.	Feb. 2, 1887	Dec. 1, 1921.
Williams, Sidney C.	Kosciusko, Miss.	Apr. 24, 1885	June 5, 1920.

## JEFFERSON BARRACKS, MO.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Abramson, Capt. Daniel J.	Piedmont, W. Va.	Dec. 25, 1912	Sept. 16, 1941.
Bondurant, Maj. Alpheus J.	Charleston, Mo.	Oct. 3, 1892	Sept. 16, 1921.
Brennan, Capt. Louis V.	O'Neil, Nebr.	Sept. 30, 1908	Oct. 16, 1939.
Briscoe, Capt. John R.	Pettis County, Mo.	Oct. 15, 1907	June 1, 1944.
Edwards, Maj. Ernest V.	Plato, Mo.	May 11, 1889	Oct. 7, 1932.
Epp, Maj. George J.	St. Louis, Mo.	Oct. 6, 1896	Mar. 17, 1939.
Faxon, Maj. Donald E.	Elgin, Ill.	Jan. 13, 1896	June 17, 1929.
Goodman, Maj. Jonathan N.	Keswick, Iowa	Oct. 3, 1898	Feb. 18, 1937.
Isaacson, Capt. Phillip A.	New York, N. Y.	Apr. 26, 1913	Dec. 1, 1941.
Levin, Capt. Abraham J.	Liverpool, England	May 1, 1909	Mar. 3, 1938.
Parker, Capt. William	Revere, Mass.	Jan. 23, 1911	Aug. 1, 1941.
Reilly, Capt. Terence M.	Brooklyn, N. Y.	June 30, 1911	Dec. 31, 1944.
Sisk, Maj. Harvey E.	Duluth, Minn.	Oct. 17, 1909	Apr. 1, 1938.
Wasserman, Capt. Sidney E.	Milwaukee, Wis.	Feb. 1, 1910	June 22, 1937.
<b>Commissioned dental officers:</b>			
Bland, First Lt. James A.	St. Louis, Mo.	July 15, 1896	Mar. 1, 1941.
Larson, Capt. Harry O.	Olivia, Minn.	Jan. 7, 1890	Dec. 19, 1921.
<b>Civilian dental officer:</b>			
Gilbert, Edward	Waupaca, Wis.	Sept. 16, 1895	Oct. 8, 1920.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## KANSAS CITY, MO.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Kelly, Maj. Alto L.....	Midland City, Ala.....	June 26, 1891	Nov. 1, 1930.
<b>ADJUDICATION ACTIVITIES</b>			
Civilian medical officers:			
Aubrey, George E.....	Stithton, Ky.....	May 9, 1889	Feb. 22, 1944.
Eye, Boyd F.....	Robinson, Kans.....	Oct. 28, 1888	May 1, 1930.

## KECOUGHTAN, VA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Bailey, Maj. James P.....	Waxahachie, Tex.....	Oct. 7, 1900	Aug. 15, 1934.
Brown, Capt. Leo R.....	Filipovo, Poland.....	May 28, 1907	Dec. 22, 1938.
Davis, Capt. Lawrence C.....	Richland Center, Wis.....	Mar. 15, 1906	July 1, 1942.
Frisch, Capt. Michael R.....	London, England.....	Nov. 21, 1903	Feb. 2, 1942.
Kelly, Lt. Col. John E.....	Sevier County, Tenn.....	June 8, 1884	Feb. 5, 1929.
King, Maj. Harold N.....	Warren, Ohio.....	Oct. 11, 1899	Aug. 23, 1930.
Kuehn, Maj. Conrad A.....	Toledo, Ohio.....	Sept. 14, 1904	Apr. 23, 1941.
Malmstead, Capt. Chester W.....	Worcester, Mass.....	Apr. 15, 1910	Aug. 1, 1941.
Migliore, First Lt. Anthony D.....	Italy.....	May 1, 1901	Oct. 16, 1941.
Miller, Maj. Benjamin.....	Bodbudkia, Russia.....	Apr. 4, 1909	May 16, 1936.
Roberts, Lt. Col. Ernest S.....	Pascagoula, Miss.....	Sept. 13, 1917	Mar. 13, 1936.
Robinson, Capt. Robert F.....	New York, N. Y.....	Feb. 26, 1913	Feb. 3, 1941.
Switkes, Maj. Herman I.....	Azernowitz, Austria.....	July 8, 1906	Aug. 8, 1938.
Civilian medical officers:			
Butzke, Ernest J.....	Beechwood, Wis.....	Dec. 10, 1877	July 19, 1928.
Dewey, Michael G.....	Ashland, Pa.....	June 2, 1889	Apr. 28, 1931.
Commissioned dental officer:			
Gray, First Lt. Joe.....	Memphis, Tenn.....	July 9, 1906	Oct. 2, 1941.
Civilian dental officers:			
Dorset, Ramon F.....	Richmond, Va.....	Oct. 20, 1891	Feb. 3, 1931.
Durham, Benjamin J.....	Shelby, N. C.....	Oct. 23, 1879	Jan. 21, 1921.

## KNOXVILLE, IOWA

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Doles, Maj. James W.....	Havre, Mont.....	June 21, 1909	Nov. 1, 1938.
Glesne, Capt. Orvin G.....	Elkader, Iowa.....	Jan. 11, 1908	Feb. 3, 1941.
Greenhouse, Capt. Abraham C.....	Poland.....	Jan. 7, 1888	Mar. 12, 1937.
Simmons, Capt. Abbott P.....	New York, N. Y.....	Jan. 9, 1908	Dec. 1, 1941.
Civilian medical officers:			
Barrett, Thomas.....	Ensworth, Pa.....	Dec. 31, 1881	Aug. 14, 1929.
Davis, George V. P.....	Philadelphia, Pa.....	Sept. 7, 1884	Mar. 12, 1923.
Dawson, Dudley.....	Scotland, Ill.....	Dec. 22, 1886	Feb. 21, 1944.
Pottori, Joseph L.....	Nevada, Mo.....	June 27, 1895	Feb. 28, 1924.
Salisbury, Frederick S.....	Broken Bow, Nebr.....	Mar. 30, 1892	July 11, 1925.
Woods, Arthur R.....	Nashua, N. H.....	Apr. 9, 1881	Feb. 18, 1925.
Commissioned dental officers:			
Gill, Capt. Harvey E.....	Minneapolis, Minn.....	Oct. 30, 1893	Mar. 1, 1922.
Plant, First Lt. Rolland D.....	Greenhill, Ind.....	Sept. 26, 1907	Feb. 27, 1942.

## LAKE CITY, FLA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Byrd, Lt. Col. Emmett E.....	No record available.....	Jan. 14, 1891	Apr. 16, 1920.
Carrozza, Capt. Natale S.....	Italy.....	Jan. 1, 1903	Sept. 16, 1942.
Isaacson, Capt. Morris.....	Brooklyn, N. Y.....	Jan. 15, 1908	May 1, 1941.
Kirkham, Lt. Col. Judd H.....	Juneau, Dodge County, Wis.....	May 18, 1889	Nov. 17, 1930.
Lustig, Capt. Julian.....	Chicago, Ill.....	Oct. 18, 1909	June 13, 1939.
Sasso, Capt. Robert M.....	Mount Vernon, N. Y.....	May 21, 1913	May 1, 1941.
Weinstein, Capt. Abraham S.....	New York City.....	July 23, 1908	May 17, 1937.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## LAKE CITY, FLA.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
<b>Civilian medical officers:</b>			
Arnold, Laurie J.....	Sanford, N. C.....	Aug. 7, 1877	Apr. 8, 1921.
Fearney, Frank A.....	Providence, R. I.....	Apr. 24, 1880	Nov. 11, 1920.
Vermilye, John H.....	Brooklyn, N. Y.....	May 3, 1888	June 20, 1921.
Vondahn, Howard C.....	Tiffin, Ohio.....	Apr. 19, 1883	Nov. 1, 1920.
<b>Commissioned dental officer:</b>			
Amick, Capt. James F.....	Liberty, N. C.....	Aug. 9, 1896	Nov. 21, 1923.

## LEGION, TEX.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Barshay, Capt. Bernard.....	Minsk, Russia.....	Sept. 3, 1902	Mar. 16, 1942.
Bruce, Lt. Col. Paul C.....	Sheakleyville, Pa.....	Dec. 20, 1890	Jan. 8, 1931.
Cassidy, Maj. William A.....	Bangor, Maine.....	Mar. 18, 1905	Aug. 1, 1938.
Davis, Capt. Daniel.....	New York, N. Y.....	Aug. 1, 1908	May 1, 1941.
Ivey, Maj. Hubert T.....	Lenoir, N. C.....	Dec. 17, 1896	Mar. 24, 1930.
Melton, Capt. Ernest I.....	Brooklyn, N. Y.....	Jan. 4, 1915	Sept. 16, 1942.
Murray, Capt. Clifford J.....	Denver, Colo.....	Feb. 10, 1907	May 1, 1941.
Pucie, Capt. Charles.....	New York, N. Y.....	Aug. 26, 1911	Nov. 2, 1942.
Weissman, Capt. Herman.....	Medjibosh, Russia.....	Mar. 22, 1899	Mar. 1, 1943.
White, Maj. Louis L.....	Yedinitz, Russia.....	Oct. 5, 1895	Mar. 16, 1942.
<b>Civilian medical officers:</b>			
Fryar, Thomas V.....	Corsicana, Tex.....	Nov. 7, 1877	Feb. 25, 1921.
Kennedy, Theodore A.....	San Mateo, Calif.....	Apr. 20, 1898	Nov. 19, 1934.
Moore, Carrol L.....	Statesboro, Ga.....	Aug. 25, 1894	Sept. 1, 1920.
Reid, Harry P.....	Friar Point, Miss.....	July 31, 1880	Apr. 1, 1931.
<b>Commissioned dental officer:</b>			
Gisin, Capt. George J.....	Denver, Colo.....	Feb. 19, 1896	Jan. 16, 1922.

## LEXINGTON, KY.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Baker, Maj. Samuel R.....	West Point, Ind.....	July 15, 1905	Jan. 20, 1931.
Cook, Maj. Arnold A.....	Toledo, Ohio.....	Jan. 5, 1906	Nov. 1, 1939.
Gail, Capt. Irving A.....	Brooklyn, N. Y.....	Nov. 23, 1910	Do.
Marren, Lt. Col. John J.....	Two Harbors, Minn.....	Apr. 20, 1904	Apr. 1, 1933.
Mayer, Capt. Frederick.....	Frankfurt-on-Main, Germany.....	Mar. 27, 1895	Dec. 3, 1930.
Miller, Lt. Col. Oliver P.....	Glenfork, Ky.....	Jan. 19, 1894	Nov. 10, 1921.
Weltman, Capt. Joseph S.....	Schenectady, N. Y.....	Oct. 17, 1910	Oct. 1, 1940.
Young, Maj. David P.....	Springfield, Ohio.....	June 18, 1896	Oct. 30, 1937.
<b>Civilian dental officer:</b>			
Marr, William W.....	Washington, D. C.....	Feb. 13, 1893	June 5, 1920.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Astrom, Algot.....	Stode, Sweden.....	Nov. 22, 1881	Apr. 21, 1941.
Nevitt, Phillip H.....	Bradenburg, Ky.....	Dec. 26, 1879	May 11, 1921.

## LINCOLN, NEBR.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Green, Maj. Ernest A.....	Winterville, Mo.....	Nov. 11, 1890	Mar. 1, 1931.
Haley, Capt. Robert R., Jr.....	Belton, Tex.....	Nov. 5, 1896	Aug. 21, 1939.
Krasner, Capt. George D.....	Brooklyn, N. Y.....	Mar. 9, 1912	May 1, 1941.
Lavender, Capt. John G.....	Omaha, Nebr.....	Apr. 8, 1918	Feb. 9, 1944.
Levin, Maj. Stanley L.....	Beaufort, S. C.....	Aug. 8, 1910	Mar. 22, 1937.
Marks, Capt. Morton G.....	New York City, N. Y.....	June 7, 1899	Feb. 23, 1937.
Mullin, Maj. Maj. Richard F.....	Omaha, Nebr.....	Nov. 19, 1883	Oct. 30, 1931.
Parrillo, Capt. Orest J.....	Naples, Italy.....	Apr. 21, 1910	May 1, 1941.
Ritter, Capt. Jerome.....	New York, N. Y.....	June 29, 1911	Oct. 1, 1940.
Wilson, Maj. Nat J.....	Vilki, Lithuania.....	Jan. 8, 1904	Jan. 23, 1935.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## LINCOLN, NEBR.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
Civilian medical officers:			
Eagleton, John .....	Decatur, Nebr. ....	June 19, 1900	Oct. 17, 1944.
Scott, Harry A .....	Edmeston, N. Y. ....	Apr. 29, 1890	Oct. 5, 1925.
Commissioned dental officer:			
Oppenheimer, Capt. Otto P. ....	Elliott County, Ky. ....	July 16, 1896	Mar. 14, 1932.
<b>ADJUDICATION ACTIVITIES</b>			
Commissioned medical officer:			
Everett, Lt. (USNR) Ernest A. ....	Emington, Ill. ....	Jan. 29, 1889	Nov. 22, 1943.
Civilian medical officer:			
Bell, David W. ....	Arlington, Nebr. ....	Jan. 12, 1879	Jan. 17, 1944.

## LITTLE ROCK, ARK.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officer:			
Broadhead, Maj. William C. ....	Clayton, Mo. ....	July 26, 1884	July 15, 1921.
<b>ADJUDICATION ACTIVITIES</b>			
Commissioned medical officers:			
Crow, Capt. Edward W. ....	Little Rock, Ark. ....	Aug. 13, 1905	Feb. 20, 1944.
Shearer, Capt. William F. ....	Cour Hill, Ark. ....	Aug. 10, 1896	Feb. 3, 1941.
Civilian medical officer:			
Wilson, Paul W. ....	Hope, Ark. ....	Mar. 21, 1897	May 1, 1930.

## LIVERMORE, CALIF.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Dunner, Capt. Edward. ....	Brooklyn, N. Y. ....	Oct. 4, 1910	Sept. 16, 1941.
Murphy, Lt. Col. Charles P. ....	Phillips, Kans. ....	Dec. 8, 1887	Jan. 1, 1921.
Putnam, Maj. Frank I. ....	Geneva, Nebr. ....	Apr. 25, 1883	Feb. 3, 1932.
Rubinstein, Capt. Morris. ....	New York, N. Y. ....	Oct. 20, 1895	Mar. 16, 1942.
Stern, Maj. Morris E. ....	do. ....	Jan. 4, 1911	Dec. 1, 1939.
Civilian medical officers:			
Beaudet, Elphege A. ....	St. Peter, Province of Quebec, Canada. ....	June 9, 1890	Apr. 24, 1922.
Harrod, Charles P. ....	Austin, Ind. ....	Nov. 16, 1885	Jan. 15, 1921.
Martin, Albert. ....	St. Anne, Ill. ....	Jan. 31, 1886	July 15, 1920.
Stinson, Henry K. ....	Lowell, Mass. ....	Nov. 28, 1875	Feb. 12, 1923.
Yankowicz, Michael. ....	McAdoo, Pa. ....	Oct. 26, 1896	June 1, 1942.
Commissioned dental officer:			
Group, Capt. Oren F. ....	Washington State. ....	July 25, 1891	Jan. 16, 1921.

## LOS ANGELES, CALIF.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Adashek, Capt. Eugene P. ....	Milwaukee, Wis. ....	Nov. 30, 1914	Sept. 16, 1941.
Adelmann, Jerome. ....	Russia. ....	Aug. 26, 1911	July 16, 1942.
Bayer, Col. Charles F. ....	Harmony, Ind. ....	May 10, 1891	Jan. 21, 1920.
Binder, Capt. Maxwell J. ....	Brooklyn, N. Y. ....	Nov. 16, 1913	May 1, 1941.
Clark, First Lt. George E. ....	Bedford, Mich. ....	Sept. 19, 1908	July 1, 1943.
Colebaugh, Lt. Col. Chas. W. ....	Radford, Va. ....	Apr. 5, 1895	Oct. 1, 1930.
Daitch, Capt. Morris B. ....	Newark, N. J. ....	June 10, 1913	Nov. 1, 1939.
Dobyns, Maj. Gypsie J. ....	Woodland, Va. ....	May 17, 1903	Mar. 1, 1937.
Fortner, Maj. Harry C. ....	Beaver Valley, Pa. ....	Nov. 8, 1890	Oct. 18, 1932.
Galtbreath, Capt. John C. ....	Morris Creek, W. Va. ....	Aug. 8, 1902	Aug. 1, 1941.
Gore, Maj. William A. ....	Lynchburg, Tenn. ....	Aug. 8, 1898	Dec. 2, 1931.
Goren, Capt. Morris L. ....	Slutsk, Russia. ....	May 25, 1908	July 5, 1933.
Harris, Col. Richard L. ....	Wrightsville, Ga. ....	Oct. 25, 1896	Mar. 1, 1921.
Holden, Maj. Isidore. ....	Southampton, England. ....	May 30, 1904	Oct. 5, 1938.
Holvey, Capt. Ervin H. ....	Milwaukee, Wis. ....	Nov. 26, 1913	Nov. 1, 1939.
Horowitz, First Lt. William. ....	New York City, N. Y. ....	Apr. 16, 1913	July 16, 1942.
Hubbard, Lt. Col. Milton E. ....	Willard, Utah. ....	Oct. 18, 1892	July 1, 1928.
Hurwich, Maj. Jerome J. ....	Chicago, Ill. ....	do. ....	Feb. 19, 1937.
Kupersmith, Capt. Harry S. ....	do. ....	Jan. 5, 1913	Feb. 1, 1940.
Lunsford, Capt. William B. ....	Roanoke, Va. ....	June 22, 1890	Feb. 21, 1931.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

LOS ANGELES, CALIF.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—Con.</b>			
<b>Commissioned medical officers—Con.</b>			
Lyons, Maj. Clinton G.	Surgionsville, Iowa	Sept. 18, 1889	Oct. 12, 1927.
Mandel, Capt. Harry	Brooklyn, N. Y.	Oct. 12, 1910	Sept. 16, 1941.
McClellan, Lt. Col. Jay H.	Statesville, N. C.	Sept. 16, 1889	Nov. 7, 1924.
Mollo, Maj. Louis D.	Philadelphia, Pa.	July 10, 1901	Jan. 4, 1932.
Morgan, Maj. Howard P.	Marshall, Tex.	May 24, 1894	Dec. 17, 1930.
Mumma, Maj. Claude S.	Forreston, Ill.	Mar. 18, 1894	Mar. 16, 1922.
Newman, Maj. Harry William	Ogden, Utah	Mar. 30, 1899	Dec. 6, 1930.
Owens, Maj. Tracy C.	Bedford, Ind.	Mar. 10, 1902	1931.
Powell, Capt. Kenneth E.	Lee, Ill.	Nov. 24, 1906	July 18, 1938.
Rabinowitz, Capt. David L.	Brooklyn, N. Y.	Aug. 17, 1909	Feb. 2, 1941.
Rock, Maj. Joseph H.	No record available	Nov. 15, 1896	Sept. 17, 1926.
Rosenberger, Capt. Maurice D.	Hancock, Ohio	Aug. 6, 1909	Oct. 1, 1940.
Sabia, Capt. Daniel J.	New York City, N. Y.	Aug. 7, 1909	Aug. 1, 1941.
Satterlee, Capt. Albert H.	Buffalo, N. Y.	July 1, 1905	Jan. 3, 1939.
Smith, Lt. Col. Horace D.	Tennille, Ga.	Apr. 27, 1903	Jan. 4, 1932.
Smith, Capt. Jack Lawrence	Vancouver, British Columbia, Canada.	May 16, 1908	Feb. 3, 1941.
Spickerman, Maj. Harold D.	Topeka, Kans.	Feb. 17, 1904	Dec. 3, 1931.
Suddeth, Capt. Leland F.	Paris, Ill.	Sept. 3, 1906	Mar. 2, 1942.
Traxler, Maj. Paul S.	Chicago, Ill.	June 4, 1893	July 6, 1931.
Van Vranken, Capt. Ralph	Passaic, N. J.	Sept. 18, 1895	Nov. 1, 1930.
Volante, Capt. Anthony J.	Philadelphia, Pa.	Feb. 21, 1910	Oct. 25, 1938.
Weiss, Capt. Benjamin J.	Pittsburgh, Pa.	Feb. 12, 1913	Nov. 1, 1939.
Woodward, Capt. Frank A.	Burlington, Iowa	Sept. 19, 1884	Jan. 23, 1928.
Ziedman, Capt. Irving	Chicago, Ill.	Sept. 16, 1906	May 16, 1936.
<b>Civilian medical officers:</b>			
Baro, Walter	No record available	Oct. 31, 1911	Sept. 1, 1944.
Basham, Rue O.	Richardville, Ky.	Feb. 12, 1892	Sept. 25, 1931.
Bowen, Ulysses	Metter, Ga.	Dec. 5, 1897	Dec. 22, 1930.
Brace, Robert W.	Blackwood, N. J.	July 21, 1875	Oct. 4, 1924.
Burnett, Edward J.	Terre Haute, Ind.	Jan. 4, 1879	May 1, 1925.
Cobb, David H.	Coaling, Ala.	Dec. 4, 1896	July 23, 1923.
Dix, Isaac	Kirkwood, W. Va.	Oct. 3, 1881	June 10, 1921.
Dubrow, James L.	Belopole, Ukraine	June 13, 1894	Sept. 21, 1931.
Dulaney, Henry P.	No record available	June 30, 1877	Mar. 1, 1913.
Gorrell, James	Churchville, Md.	Nov. 3, 1898	Aug. 1, 1941.
Hantsch, Ferdinand K.	Friedek, Austrian Silesia	Jan. 26, 1892	July 16, 1928.
Long, Frank L.	De Soto, Mo.	Nov. 18, 1882	Jan. 17, 1920.
Nigh, John W.	No record available	Nov. 11, 1884	Feb. 16, 1930.
Pache, Francis C.	Stockton, Calif.	June 7, 1876	Oct. 1, 1921.
Paynter, Harrison	Des Moines, Iowa	July 21, 1888	Mar. 1, 1941.
Ramer, E. Blanche	No record available	Aug. 23, 1890	July 26, 1944.
Rosow, Herman	do	July 25, 1907	Mar. 4, 1938.
Scott, Robert	Donaldson, Minn.	Sept. 29, 1885	Dec. 4, 1944.
<b>Commissioned dental officers:</b>			
Neal, First Lt. Homer S.	Carrollton, Miss.	Mar. 23, 1891	Dec. 15, 1930.
Saubert, Maj. Walter J.	Kaukauna, Wis.	Oct. 16, 1886	June 12, 1922.
Van Aken, First Lt. Ray C.	No record available	Nov. 16, 1893	Sept. 16, 1943.
Williams, Capt. Charles R.	Denver, Colo.	July 24, 1897	Feb. 1, 1922.
<b>Civilian dental officer:</b>			
Denson, Roy L.	Hallettsville, Tex.	Jan. 9, 1892	Oct. 1, 1921.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Commissioned medical officer:</b>			
Dixon, Capt. William B.	Spirit Lake, Iowa	Dec. 17, 1896	Apr. 17, 1942.
<b>Civilian medical officers:</b>			
Kallock, Dudley	Stapleton, Staten Island, N. Y.	Dec. 10, 1883	Oct. 1, 1931.
Paulson, George	Davenport, Iowa	Feb. 4, 1886	Jan. 24, 1944.
Phares, Willard	Jacksonburg, Ohio	Apr. 12, 1880	Mar. 19, 1938.
Roach, Richard A.	Chicago, Ill.	Oct. 18, 1883	Nov. 1, 1920.
Strickland, Clarence R.	Greenfield, Ind.	May 18, 1882	Feb. 21, 1944.
Zimmerman, Randall	Stoystown, Pa.	July 29, 1879	Dec. 4, 1944.

## LYONS, N. J.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Fagley, Maj. Raymond C.	Shamokin, Pa.	Nov. 19, 1887	May 17, 1935.
Flood, Maj. William A.	Waloomsac, N. Y.	May 23, 1887	Mar. 10, 1921.
Gardner, Capt. Sidney M.	Denver, Colo.	Sept. 13, 1906	Apr. 1, 1938.
Giannini, Capt. Francis F.	Italy	Dec. 25, 1908	Sept. 16, 1942.
Hawkins, First Lt. William B.	Little Rock, Ark.	Aug. 4, 1912	
Hoffman, Capt. Harry	Philadelphia, Pa.	Nov. 5, 1909	Nov. 1, 1939.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## LYONS, N. J.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
<b>Commissioned medical officers—Con.</b>			
Kaplan, Capt. Leonard A.	Brooklyn, N. Y.	Jan. 8, 1914	Mar. 16, 1942.
Loeb, Maj. William A.	New York, N. Y.	Feb. 28, 1906	Mar. 9, 1935.
Lopez, Lt. Col. Louis V.	New Orleans, La.	Jan. 7, 1894	June 14, 1920.
Michaels, Capt. Joseph.	New York City, N. Y.	July 12, 1911	Feb. 3, 1941.
Mischler, Jay E.	Atlantic City, N. J.	Feb. 15, 1912	Feb. 2, 1942.
Presberg, Maj. Mowey.	Rochester, N. Y.	Oct. 1, 1904	Jan. 6, 1936.
Rainone, Capt. Salvatore.	Brooklyn, N. Y.	Dec. 14, 1907	Feb. 2, 1942.
Roecker, Capt. Roland D.	do.	Mar. 30, 1912	Nov. 1, 1939.
Sewall, Maj. Lee G.	Marlin, Tex.	Aug. 25, 1907	Mar. 7, 1939.
Weitz, Maj. Paul.	Czernaawitz, Austria.	Oct. 30, 1903	Jan. 15, 1935.
<b>Civilian medical officers:</b>			
Hinckley, Livingston S.	Newark, N. J.	Apr. 23, 1893	Oct. 31, 1935.
Hirschhoff, Ernest A. F.	Dresden, Germany.	July 28, 1880	July 6, 1925.
Strotz, Charles M.	Philadelphia, Pa.	June 12, 1881	May 1, 1921.
<b>Commissioned dental officers:</b>			
Scopp, Capt. Irwin W.	New York, N. Y.	Dec. 8, 1909	July 22, 1942.
Zercher, Maj. Joseph E.	Topeka, Kans.	May 9, 1895	July 16, 1921.
<b>Civilian dental officer:</b>			
Whyte, Isaac H.	Chester County, Pa.	Feb. 1, 1877	Aug. 16, 1921.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officer:</b>			
Gordon, Edward J.	Newburgh, N. Y.	July 1, 1875	Feb. 20, 1929.

## MANCHESTER, N. H.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Civilian medical officers:</b>			
Drury, Forrest J.	Easton, N. H.	Jan. 17, 1885	Dec. 16, 1930.
Maby, Aloysius D.	Cohoes, N. Y.	Oct. 31, 1892	Nov. 1, 1921.

## MARION, ILL.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Ailts, Capt. Bernard H.	Pekin, Ill.	May 29, 1913	Jan. 15, 1940.
Michaelson, Maj. Leon J.	Rochester, N. Y.	Oct. 28, 1913	Do.
Navin, Maj. James J.	Norwalk, Ohio.	Aug. 6, 1898	Jan. 6, 1932.
Shawver, Lt. Col. John R.	Knox County, Tex.	Feb. 11, 1907	Jan. 3, 1935.
<b>Civilian medical officers:</b>			
Gorisse, Gustave.	Rahway, N. J.	Oct. 26, 1887	June 6, 1944.
Hunsaker, Curtis A.	Colden, Ill.	Sept. 10, 1887	Jan. 15, 1927.
Welch, Edward A.	Springfield, Ohio.	May 26, 1890	Mar. 22, 1920.

## MARION, IND.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Argent, Capt. Albert H.	Leova, Rumania.	Apr. 12, 1912	Oct. 16, 1941.
Bean, Lt. Col. Victor H.	Fulton, Mass.	Apr. 6, 1886	Aug. 4, 1929.
Botts, Col. Harry H.	Lebanon, Ind.	June 2, 1889	Jan. 15, 1923.
Bourke, Maj. William W.	Horton, Kans.	Oct. 31, 1902	Feb. 16, 1931.
Faust, Capt. Walter H.	Altus, Ark.	Sept. 9, 1911	Nov. 1, 1941.
Ginberg, Maj. Stewart T.	St. Paul, Minn.	Apr. 18, 1906	Jan. 7, 1936.
Hockett, Capt. Harry G.	Anderson, Ind.	Sept. 11, 1903	July 1, 1942.
Jones, Maj. Ernest F.	Milton, Ind.	Mar. 23, 1900	Dec. 10, 1940.
Milone, First Lt. Joseph E.	New York, N. Y.	Sept. 28, 1914	Jan. 4, 1943.
Weinstein, Capt. Louis.	Odessa, Russia.	Apr. 19, 1895	June 15, 1942.
<b>Commissioned dental officer:</b>			
Helck, Capt. Solomon A.	Grayville, Ill.	Feb. 19, 1882	Mar. 28, 1932.
<b>Civilian dental officer:</b>			
Van Brackle, Woodfin H.	Clyde, Ga.	Aug. 12, 1891	May 6, 1925.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## MEMPHIS, TENN.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Boals, Maj. John O.....	Williston, Tenn.....	July 16, 1886	Apr. 16, 1921.
Damashek, Capt. Samuel.....	New York, N. Y.....	Jan. 18, 1910	July 8, 1940.
Dougherty, Maj. Hugh Robert.....	Ashland, Pa.....	Oct. 4, 1903	Oct. 16, 1939.
Foster, Lt. Col., Robert Heath.....	Shiloh, Miss.....	Sept. 13, 1884	Jan. 21, 1933.
Gross, Capt. Victor L.....	New York, N. Y.....	Oct. 18, 1899	Mar. 16, 1942.
Levin, Capt. Jack.....	No record available	Jan. 26, 1912	May 1, 1941.
McCann, Maj. Ezelle.....	Kewanee, Miss.....	May 13, 1885	Jan. 15, 1923.
Rapp, Maj. Edwin Wallace.....	Aurora, Ill.....	Apr. 18, 1891	Apr. 16, 1932.
Rosenkranz, Maj. Otto H.....	Duisburg, Germany.....	Jan. 15, 1882	Aug. 1, 1920.
Skinner, Capt. Morgan.....	Waupaca, Wis.....	Jan. 12, 1905	May 22, 1936.
Wheeler, Lt. Col. Joseph Ed.....	Meridian, Miss.....	Sept. 5, 1892	July 6, 1919.
<b>Civilian medical officers:</b>			
Cooper, Arthur F.....	Trenton, Tenn.....	Aug. 26, 1881	May 27, 1944.
Dodge, Horace C.....	Boulder, Colo.....	Mar. 14, 1877	Sept. 3, 1919.
Isherwood, Ainsworth V.....	Drocut, Mass.....	Oct. 1, 1899	Mar. 1, 1943.
Love, John M.....	Amherst, Va.....	May 24, 1878	May 5, 1934.
Patton, Marion L.....	Bells, Tenn.....	Dec. 4, 1898	Apr. 1, 1942.
<b>Commissioned dental officer:</b>			
Bergeron, Capt. Maximilian P.....	Hinesdale, N. H.....	June 6, 1886	July 5, 1928.
<b>Civilian dental officer:</b>			
Reinert, Adrian.....	Centerville, Wis.....	Jan. 27, 1906	Jan. 6, 1944.

## MENDOTA, WIS.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Owens, Capt. Clarence G.....	Crookston, Minn.....	May 21, 1903	Dec. 1, 1941.
Spiro, Capt. Harry M.....	Boston, Mass.....	Sept. 2, 1913	Mar. 2, 1942.
Tompkins, Lt. Col. Harvey J.....	Chicago, Ill.....	May 14, 1906	July 2, 1935.
Trent, Lt. Col. Letcher E.....	North Carolina.....	Sept. 26, 1883	Mar. 9, 1922.
Zolondek, 1st Lt., Sol.....	Poland.....	Dec. 15, 1908	Sept. 16, 1942.
<b>Civilian medical officer:</b>			
Singleton, Dennis E.....	Paris, Mo.....	June 21, 1882	Sept. 1, 1939.
<b>Civilian dental officer:</b>			
Harrymau, John W.....	No record available.....	May 17, 1894	Apr. 9, 1937.

## MINNEAPOLIS, MINN.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Bank, Maj. Harry E.....	Milwaukee, Minn.....	Apr. 28, 1891	Jan. 15, 1920.
Bundy, Lt. Col. Harry E.....	Aurora, Ill.....	Dec. 19, 1889	May 14, 1928.
Falk, Capt. Abraham.....	New York, N. Y.....	May 27, 1905	Nov. 1, 1939.
Golden, Capt. Howard.....	Bronx, N. Y.....	Aug. 8, 1915	Sept. 16, 1942.
Hentel, Maj. William.....	New York, N. Y.....	Aug. 25, 1911	May 1, 1941.
Katz, Capt. Louis J.....	St. Paul, Minn.....	Oct. 2, 1908	Feb. 3, 1941.
Litman, Maj. Morris H.....	Kaneko, Russia.....	Mar. 15, 1899	Apr. 1, 1930.
Mandell, Capt. Edward H.....	New York, N. Y.....	Jan. 23, 1899	June 1, 1942.
McGregor, Capt. Catherine G.....	No record available.....	Dec. 12, 1891	Apr. 21, 1944.
Minsky, Capt. Armen A.....	Russia.....	Mar. 30, 1904	Nov. 3, 1929.
Myers, Maj. Harry A.....	Herman, Ill.....	Feb. 4, 1890	Apr. 1, 1921.
Neal, Maj. Joe M.....	Gallipolis, Ohio.....	Aug. 26, 1892	Aug. 2, 1920.
Noonan, Capt. Dan Francis.....	Waverly, Minn.....	Dec. 29, 1883	Apr. 4, 1944.
Schwalbe, Maj. Milton I.....	New York City, N. Y.....	June 2, 1889	Dec. 23, 1940.
Utendorfer, Capt. Robert W.....	Harvey, N. Dak.....	May 22, 1912	Apr. 1, 1944.
Westphal, Maj. Kean F.....	Pleasant Grove, Utah.....	Dec. 21, 1911	Nov. 1, 1939.
Ziskin, Maj. Thomas.....	Grand Forks, N. Dak.....	Nov. 29, 1888	Oct. 25, 1921.
<b>Civilian medical officers:</b>			
Abbott, John S.....	St. Paul, Minn.....	Nov. 15, 1883	Dec. 1, 1944.
Burdick, Charles H.....	St. Louis, Mo.....	Aug. 1, 1886	July 5, 1929.
De Courcy, Donald.....	St. Paul, Minn.....	Mar. 3, 1901	June 20, 1930.
Hanson, Henry V.....	Hutchinson, Minn.....	Jan. 21, 1889	Jan. 29, 1923.
Jensen, Louis C.....	Denmark.....	June 10, 1888	Aug. 23, 1921.
Josowich, Alexander.....	Milwaukee, Wis.....	July 4, 1890	May 1, 1922.
Nelson, Edwin G.....	La Porte, Ind.....	Aug. 26, 1890	July 18, 1921.
Nelson, Oscar L.....	Minneapolis, Minn.....	Apr. 13, 1894	Nov. 8, 1937.
Seaberg, John A.....	Evanston, Ill.....	Mar. 9, 1890	Aug. 15, 1928.
<b>Commissioned dental officers:</b>			
Payne, Maj. Ralph S.....	Wabasha, Minn.....	Sept. 16, 1895	Apr. 10, 1921.
Yonover, First Lt. Nathan.....	No record available.....	Mar. 20, 1900	Apr. 1, 1944.
<b>Civilian dental officer:</b>			
Koontz, Sylvester.....	Glenville, Minn.....	June 27, 1889	Jan. 1, 1921.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## MINNEAPOLIS, MINN.—Continued

Name	Place of birth	Date of birth	Date of appointment
ADJUDICATION ACTIVITIES			
Commissioned medical officer: Sanderson, Capt. Oscar M.....	Minnesota, Minn.....	June 2, 1889	Oct. 2, 1944.
Civilian medical officers: Engdahl, Fred.....	Wilbank, S. Dak.....	Feb. 27, 1891	Mar. 30, 1944.
Fahey, Edward S.....	Kingston, Ontario, Canada.....	Nov. 18, 1876	Mar. 1, 1945.
Joyner, Nevil M.....	Mason, Tenn.....	Mar. 24, 1899	Dec. 10, 1942.
Ricketts, Floyd.....	Jeffersonville, Ind.....	Dec. 13, 1889	Feb. 16, 1944.
Scanlan, Jerome E.....	St. Paul, Minn.....	Oct. 16, 1898	Jan. 19, 1944.

## MONTGOMERY, ALA.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers: Bailey, Maj. Marion P.....	Charleston, S. C.....	Jan. 26, 1893	June 5, 1935.
Bernell, Capt. Stanley P.....	Camden, N. J.....	Feb. 14, 1913	Feb. 2, 1942.
Rosenfeld, Capt. Frederick.....	Brooklyn, N. Y.....	Feb. 8, 1866	Dec. 21, 1936.
Schmitt, Capt. Robert W.....	Nichols, Iowa.....	Nov. 20, 1908	Feb. 1, 1940.
Witten, Capt. Morris.....	Brooklyn, N. Y.....	Mar. 27, 1913	Nov. 1, 1941.
Civilian medical officers: Fisk, Harley B.....	Fiskburg, Ky.....	Feb. 19, 1890	Sept. 27, 1930.
Kienhoff, George W.....	Troy, Kans.....	May 17, 1885	Jan. 10, 1921.
Newhauser, Mayer A.....	Monore, La.....	Feb. 26, 1883	May 20, 1920.
Pafford, Jefferson W.....	Cafee County, Ga.....	Mar. 20, 1889	Sept. 17, 1931.
Weinrib, Joseph.....	New York, N. Y.....	Dec. 23, 1904	Dec. 2, 1940.
Commissioned dental officer: Miller, Capt. James L.....	Carthage, Tex.....	May 11, 1882	May 3, 1922.
ADJUDICATION ACTIVITIES			
Commissioned medical officer: Garrett, Capt. James DeWitt.....	Mount Carmel, Ala.....	Dec. 27, 1888	Mar. 1, 1944.
Civilian medical officers: Reagan, Cas.....	Delta, Ala.....	Sept. 12, 1889	Jan. 16, 1940.
Stanley, William A.....	Opp, Ala.....	Mar. 22, 1890	Feb. 1, 1944.

## MOUNTAIN HOME, TENN.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers: Blau, First Lt. Leslie.....	Hungary.....	June 5, 1912	Sept. 16, 1943.
Crouch, Maj. Henry W.....	Charleston, S. C.....	Feb. 9, 1900	Mar. 13, 1936.
Frankenthaler, Capt. Sylvan A.....	Neva, Tenn.....	Aug. 13, 1904	Apr. 1, 1942.
Gambill, Maj. Ira M.....	Neva, Tenn.....	June 18, 1894	Nov. 6, 1931.
Good, Lt. Col. Richard W.....	Corning, Iowa.....	Mar. 3, 1896	June 15, 1926.
Kantor, Capt. Milton.....	Bronx, N. Y.....	Jan. 27, 1912	May 1, 1941.
Knapp, Capt. John A.....	Union, N. Y.....	Aug. 25, 1914	June 15, 1942.
Levy, Capt. Bertram L.....	Staten Island, N. Y.....	Mar. 6, 1910	Nov. 1, 1939.
Morison, Lt. Col. James H. S.....	Ewing, Va.....	Dec. 4, 1885	Sept. 15, 1934.
Prescott, Capt. Kenneth H.....	Bloomfield, Nebr.....	Dec. 19, 1909	July 6, 1938.
Russek, Capt. Allen S.....	Brooklyn, N. Y.....	Feb. 16, 1907	Feb. 2, 1942.
Slade, Lt. Col. Charles K.....	Willacoochee, Ga.....	June 14, 1907	July 1, 1937.
Waring, Maj. Harold R.....	Tyrone, Pa.....	Dec. 4, 1899	Jan. 2, 1942.
Werner, Maj. Emil A.....	Crete, Ill.....	Dec. 14, 1890	July 11, 1921.
Civilian medical officer: Carpenter, John D.....	No record available.....	Mar. 29, 1880	Feb. 1, 1928.
Commissioned dental officers: McDowell, First Lt. Harvey E.....	Smithfield, Nebr.....	July 3, 1903	Oct. 14, 1940.
Nixon, Capt. Marvin O.....	No record available.....	Sept. 4, 1906	Oct. 2, 1941.
Talbert, Maj. Harry V.....	Hancock County, Ind.....	Oct. 30, 1888	June 1, 1930.

## MURFREESBORO, TENN.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers: Abel, Maj. Samuel E.....	No record available.....	Jan. 27, 1907	Jan. 1, 1945.
Adams, Maj. Charles C.....	Manchester, Ill.....	Apr. 25, 1890	Mar. 2, 1931.
Dodd, Maj. David William.....	Vevay, Ind.....	July 7, 1892	Oct. 14, 1921.
Hawkins, Capt. Henry M.....	Magnolia, Ark.....	May 9, 1910	Nov. 1, 1939.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## MURFREESBORO, TENN.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
<b>Commissioned medical officers—Con.</b>			
Jerrell, Maj. Paul M.....	Nobleville, Ind.....	Feb. 25, 1895	Oct. 15, 1930.
Lawn, Maj. Harold J.....	Minneapolis, Minn.....	Oct. 28, 1911	Apr. 3, 1937.
Martin, Capt. William D.....	Gladeville, Tenn.....	Apr. 22, 1886	May 1, 1944.
Moore, Capt. George B.....	Madison, Ark.....	June 23, 1907	Feb. 6, 1939.
Rosenberg, Capt. George.....	New York, N. Y.....	Sept. 2, 1896	Mar. 16, 1942.
<b>Civilian medical officers:</b>			
Covey, Clyde B.....	Buffalo, N. Y.....	Dec. 13, 1887	Feb. 15, 1920.
Moore, John F.....	Washington, D. C.....	June 19, 1899	May 16, 1939.
White, Alvah W.....	Upatoie, Ga.....	Oct. 10, 1888	Dec. 31, 1928.
<b>Civilian dental officers:</b>			
Meyer, Frank E.....	Lexington, Mo.....	Jan. 12, 1887	Sept. 5, 1922.
Phillips, Fred O.....	Huntsville, Tenn.....	Aug. 15, 1882	Feb. 18, 1922.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Commissioned medical officers:</b>			
Glass, USNR, Lt. Sidney H.....	Phoenix City, Ala.....	Apr. 11, 1898	Feb. 24, 1931.
Herndon, Capt. Zelma Lamb.....	Bement, Ill.....	Nov. 13, 1902	Jan. 25, 1944.
<b>Civilian medical officers:</b>			
Barker, Hampton M.....	Alabama.....	Mar. 14, 1876	Apr. 16, 1945.
Hind, John C.....	Brookfield, Ga.....	Sept. 3, 1892	Mar. 1, 1930.

## MUSKOGEE, OKLA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Alexander, Maj. Gilbert H.....	Brooklyn, N. Y.....	Nov. 6, 1908	Feb. 14, 1938.
Bates, Lt. Col. Clarence E.....	Westire, Okla.....	June 30, 1894	Jan. 2, 1925.
Dougherty, Maj. Arthur McI.....	Litchfield, Minn.....	Aug. 8, 1901	Jan. 16, 1940.
Mengel, Capt. Chester K.....	McAlester, Okla.....	Jan. 21, 1915	Aug. 1, 1941.
Miller, Maj. Daniel H.....	Clatonia, Nebr.....	Oct. 31, 1899	June 6, 1932.
Parker, Maj. James H.....	Berryman, Mo.....	Sept. 25, 1886	July 16, 1930.
Rome, Capt. Albert.....	Boston, Mass.....	May 6, 1907	Jan. 12, 1938.
Turner, Capt. Ralph D.....	Emporia, Kans.....	Aug. 1, 1909	Dec. 16, 1941.
<b>Civilian medical officers:</b>			
Dyer, James H.....	Shelbyville, Tenn.....	Oct. 8, 1875	June 20, 1921.
Freund, Norman L.....	New York, N. Y.....	Jan. 17, 1914	Nov. 15, 1944.
Mitchell, Robert.....	Oklahoma Del. district, Indian Territory.....	Apr. 10, 1876	Dec. 3, 1921.
Mollica, Stephen.....	Lipari, Italy.....	July 16, 1893	Jan. 5, 1931.
Robinson, Charles.....	Hernando De Soto County, Mississippi.....	July 17, 1889	Mar. 1, 1920.
<b>Commissioned Dental Officer:</b>			
Patriquin, Capt. Forrest D.....	Newburyport, Mass.....	June 23, 1898	May 2, 1930.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Athey, Clanton R.....	Grenshaw County, Ala.....	Dec. 6, 1886	May 17, 1930.
Davis, Emmer P.....	Slantloud, Mo.....	Mar. 25, 1884	Jan. 28, 1944.

## NEWINGTON, CONN.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officer:</b>			
Boswell, Maj. Clay S.....	Illinois.....	Feb. 8, 1898	Dec. 1, 1931.
Bowen, Capt. Francis D.....	Grantsville, Md.....	Dec. 2, 1916	July 1, 1943.
Brillman, First Lt. Lester P.....	No record available.....	Jan. 21, 1912	Dec. 2, 1940.
Cook, Lt. Col. Ambrose H.....	Cincinnati, Ohio.....	Jan. 17, 1902	Oct. 16, 1928.
Dressler, Capt. Morris.....	New York, N. Y.....	Oct. 14, 1902	June 1, 1942.
Fleri, Capt. Santo Howard.....	Brooklyn, N. Y.....	Feb. 19, 1901	Mar. 16, 1942.
Fox, Capt. Sidney.....	New York, N. Y.....	Feb. 16, 1914	Aug. 1, 1941.
Marcus, Capt. Emanuel.....	Brooklyn, N. Y.....	Jan. 27, 1909	Do.
Messina, Maj. Michael C.....	Italy.....	Aug. 8, 1901	Mar. 2, 1931.
Musa, Maj. Agba B.....	Tabriz, Iran.....	July 18, 1888	Apr. 4, 1927.
Preston, Lt. Col. Thomas R.....	New Haven, Conn.....	Sept. 2, 1899	June 1, 1928.
Prignano, Capt. John Vincent.....	New York City, N. Y.....	Dec. 20, 1914	July 16, 1942.
Schwartz, Capt. George R.....	Milwaukee, Wis.....	Jan. 16, 1907	Aug. 22, 1935.
Whiting, Capt. Herbert S.....	New York, N. Y.....	Jan. 28, 1906	Feb. 3, 1941.



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## NEWINGTON, CONN.—Con.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
Civilian medical officers:			
Baskin, Abraham .....	Lepew, Russia .....	June 8, 1907	Jan. 16, 1939.
Brennand, Everett C. ....	Providence, R. I. ....	Aug. 7, 1873	Dec. 29, 1919.
McGovern, Edward .....	Bridgeport, Conn. ....	Jan. 24, 1875	Sept. 1, 1935.
Commissioned dental officers:			
Goldstein, 1st Lt. Hyman ..	Russia .....	Oct. 15, 1904	Jan. 17, 1942.
Robbins, Capt. Clement J., Jr. ....	Hampton, Va. ....	Apr. 3, 1900	Aug. 1, 1930.
<b>ADJUDICATION ACTIVITIES</b>			
Commissioned medical officers:			
Egan, Capt. John Joseph .....	No record available .....	May 15, 1885	Aug. 3, 1944.
Civilian medical officers:			
Farley, Edward B. ....	do .....	Oct. 19, 1885	Apr. 9, 1945.
Tyler, Herman A. ....	East Hartford, Conn. ....	Aug. 13, 1877	Mar. 5, 1930.

## NEW ORLEANS, LA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Beranger, Maj. Edgar J. ....	New Orleans, La. ....	Aug. 27, 1892	Feb. 24, 1920.
Di Tata, Maj. Domenick .....	New York City, N. Y. ....	June 2, 1908	Nov. 1, 1939.
Musfelt, Capt. William S. ....	Long Pine, Nebr. ....	Nov. 22, 1902	No record available.
Wiernik, Capt. Harris .....	Brooklyn, N. Y. ....	Apr. 25, 1908	Apr. 1, 1942.
Zaller, Capt. Seymour .....	New York City, N. Y. ....	Apr. 4, 1903	No record available.
Civilian medical officer:			
Guillotte, William F. ....	No record available .....	Sept. 15, 1878	June 1, 1944.
<b>ADJUDICATION ACTIVITIES</b>			
Civilian medical officers:			
Mariette, George C. ....	Trilla, Ill. ....	Feb. 5, 1888	Apr. 30, 1930.
Otto, Henry J. ....	New Orleans, La. ....	June 29, 1879	Feb. 14, 1944.
Trepangier, Dalton .....	do .....	Sept. 27, 1898	Mar. 30, 1944.

## NEW YORK, N. Y.—REGIONAL OFFICE

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned dental officers:			
O'Brien, Capt. Arthur G. ....	Brooklyn, N. Y. ....	May 25, 1895	Jan. 9, 1940.
Westmoreland, Capt. William W. ....	No record available .....	Mar. 23, 1888	Feb. 1, 1922.
<b>ADJUDICATION ACTIVITIES</b>			
Commissioned medical officers:			
Fink, Capt. Frank E. ....	do .....	Oct. 14, 1895	Jan. 11, 1944.
Holzberg, Capt. Ida Ruth .....	do .....	June 28, 1898	Jan. 19, 1944.
Livant, Capt. Saul. ....	do .....	June 6, 1905	July 13, 1943.
Michaels, Capt. Leo .....	do .....	Aug. 24, 1893	Jan. 21, 1944.
Civilian medical officers:			
Little, Zack J. ....	Franklin Mills, Pa. ....	July 31, 1876	Apr. 20, 1931.
Barron, William Power .....	Rusk, Tex. ....	June 8, 1877	Apr. 1, 1920.
Dryfus, Milton L. ....	New Haven, Conn. ....	Oct. 26, 1890	Dec. 21, 1944.
Friedman, Edward L. ....	Carmel, N. J. ....	Feb. 24, 1885	Dec. 12, 1941.
Harberg, Hyman .....	Bronx, N. Y. ....	do .....	Jan. 19, 1944.
Jacobs, William I. ....	New York, N. Y. ....	Mar. 4, 1897	Jan. 11, 1944.
Kliger, Max .....	Odessa, Russia .....	Oct. 15, 1893	Jan. 3, 1944.
Liotta, Matthew .....	Italy .....	Sept. 20, 1886	Dec. 27, 1943.
Musante, Joseph .....	Astoria, Long Island, N. Y. ....	Dec. 19, 1889	Jan. 21, 1944.
O'Connor, Eugene T. ....	Utica, N. Y. ....	Aug. 23, 1880	Jan. 26, 1920.
Rosenberg, David .....	Brooklyn, N. Y. ....	Oct. 13, 1896	Jan. 12, 1944.
Rubinowitz, Alexander H. ....	New York, N. Y. ....	July 23, 1887	Jan. 12, 1944.
Sherwood, Arthur .....	Hew Haven, Conn. ....	Apr. 4, 1896	Feb. 14, 1944.
Walther, John W. ....	Coburg, Germany .....	Oct. 12, 1880	Dec. 5, 1944.
Weinauer, Heribert .....	Passau, Germany .....	May 14, 1899	Dec. 8, 1943.
Wiener, Isidore K. ....	Newark, N. J. ....	May 11, 1884	Dec. 18, 1944.
Chaney, Herbert M. ....	City not given, Ohio .....	July 14, 1873	Jan. 22, 1945.
Looram, James F. ....	New York City .....	Nov. 22, 1888	Mar. 1, 1940.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## NORTHAMPTON, MASS.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Brown, Maj. Ralph W.	La Porte City, Iowa.	June 24, 1886	Nov. 15, 1920.
Dobson, Col. William M.	New Brunswick, Canada.	Dec. 5, 1883	Mar. 16, 1929.
Harris, Capt. Albert E.	Pittsburgh, Pa.	May 17, 1910	June 1, 1942.
Kasper, Capt. Louis	New York, N. Y.	May 26, 1910	June 15, 1942.
O'Neil, Lt. Col. Richard T.	Vicksburg, Miss.	June 5, 1889	Jan. 15, 1923.
Plumb, Maj. Darley G.	Kirwin, Kans.	Aug. 23, 1883	Nov. 4, 1920.
Civilian medical officers:			
Mayer, Stephen K.	Mainz, Germany	Nov. 20, 1890	Nov. 17, 1943.
Steele, Fred E.	Stockbridge, Vt.	Sept. 11, 1883	Aug. 15, 1919.
Civilian dental officer:			
Rogers, Francis.	Southboro, Mass.	Oct. 26, 1878	Dec. 8, 1920.

## NORTH LITTLE ROCK, ARK.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Campbell, Col. Duncan D.	Rochester, N. Y.	July 20, 1885	May 1, 1924.
Denning, Capt. Philip P.	Flushing, N. Y.	Sept. 17, 1905	Feb. 2, 1942.
Doherty, Maj. William R.	Ohio	Oct. 4, 1912	Dec. 1, 1939.
Mallin, First Lt. Aaron W.	Philadelphia, Pa.	Oct. 16, 1913	No record available.
Riley, Maj. Wilbur K.	Wisner, Nebr.	Sept. 24, 1892	July 16, 1930.
Robinson, Maj. Joseph A.	Fort Worth, Tex.	May 1, 1890	July 8, 1923.
Snyderman, Capt. Henry	Vilno, Lithuania.	Jan. 1, 1894	June 1, 1942.
Stathakis, Capt. John	Sparta, Greece	May 10, 1904	Do.
Thomas, Capt. Theodore, J.	Narka, Kans.	July 24, 1904	Oct. 16, 1941.
Walsh, Maj. William V.	St. Paul, Minn.	Sept. 8, 1910	Nov. 1, 1939.
Wiggins, Maj. Charles Henry	Scobba, Miss.	Oct. 17, 1899	Apr. 19, 1935.
Civilian medical officers:			
Harkey, Clifford.	Graves County, Ky.	Jan. 7, 1881	Mar. 17, 1921.
Toney, Lee E.	Missouri	Apr. 22, 1886	June 17, 1935.
Commissioned dental officer:			
Adams, Capt. Ward A.	Ozark, Mo.	Nov. 11, 1891	Apr. 14, 1921.

## NORTHPORT, LONG ISLAND, N. Y.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
Commissioned medical officers:			
Carra, First Lt. Angelo D.	New York, N. Y.	Oct. 26, 1914	Aug. 7, 1944.
Dancik, Capt. Daniel	Brooklyn, N. Y.	Mar. 27, 1911	Dec. 2, 1940.
Drake, Capt. Robert J.	Severance, Kans.	Oct. 31, 1889	Dec. 1, 1941.
Foster, Lt. Col. Harold E.	Owego, Tioga County, N. Y.	June 1, 1884	Sept. 21, 1927.
Hawkes, Capt. James Henry			
Huddleson, Lt. Col. James H.	Rosamond, Ill.	Nov. 18, 1908	July 8, 1940.
Kashe, Capt. Leo H.	Portland, Oreg.	Mar. 15, 1887	Aug. 2, 1941.
Naples, Maj. Angelo S.	Granby, Canada.	July 27, 1903	Nov. 2, 1942.
Steinberg, First Lt. Edgar I.	Buffalo, N. Y.	Aug. 31, 1903	July 5, 1935.
Turner, Maj. William J.	Philadelphia, Pa.	Oct. 24, 1914	Mar. 2, 1942.
Verdel, Col. Louis F.	Wilksburg, Pa.	Sept. 22, 1907	Feb. 6, 1937.
Civilian medical officers:			
Brown, Leonard	Memphis, Tenn.	Jan. 24, 1894	Jan. 1, 1922.
Drubin, Lester	New York City	Nov. 15, 1883	Nov. 15, 1924.
Gilbert, Rich	Brooklyn, N. Y.	Mar. 8, 1913	Oct. 1, 1940.
Hermann, M. E.	New York City	Nov. 10, 1912	Sept. 16, 1942.
Lazell, Edward	Austria	Oct. 18, 1900	Oct. 2, 1944.
Triolo, Antonino	Boston, Mass.	Aug. 3, 1878	Dec. 6, 1921.
Commissioned dental officers:			
Bourquin, Capt. Justin W.	Polerius, Italy	Nov. 29, 1896	Feb. 16, 1931.
Weston, First Lt. Michael E.	Pidionte, Pa.	Jan. 3, 1891	July 25, 1935.
Civilian dental officer:			
Swartz, Leroy W.	Russia	May 18, 1907	Dec. 7, 1939.
	Ickesburg, Pa.	Jan. 3, 1880	June 1, 1921.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## OTTEEN, N. C.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Anolik, First Lt. William	New York, N. Y.	Feb. 2, 1916	Jan. 17, 1944.
Ashley, Capt. Moe	do	Jan. 30, 1913	Mar. 16, 1942.
Bernstein, Maj. David	Minsk, Russia	Oct. 20, 1910	Mar. 13, 1941.
Beverly, Maj. Squire S.	Richfield, Ohio	Sept. 6, 1889	Nov. 21, 1927.
Gruenwald, Capt. Charles	Warsaw, Poland	Oct. 13, 1906	Feb. 2, 1942.
Jacobs, Capt. Paul	Pennsylvania	Apr. 9, 1905	Apr. 26, 1937.
Kraus, Capt. Albert	New York, N. Y.	July 17, 1907	No record available.
McAllister, Lt. Col. Max F.	Fayetteville, Ark.	May 2, 1904	Do.
Murphy, Lt. Col. James D.	Brookings, S. Dak.	Nov. 2, 1895	Mar. 10, 1939.
Quinn, Lt. Col. David E.	Dennison, Ohio	Apr. 30, 1901	Feb. 1, 1932.
Rauchwerger, Capt. Solomon M.	New York City, N. Y.	June 19, 1908	Dec. 2, 1940.
Rogers, Capt. Raymond J.	Oconto, Wis.	Sept. 20, 1906	Feb. 3, 1941.
Sedofsky, Maj. Nathan	New York City	June 1, 1910	Feb. 16, 1937.
Speir, Maj. Charles H.	Bay City, Mich.	Oct. 13, 1900	Mar. 2, 1942.
Spencer, Capt. Samuel	Boston, Mass.	Jan. 18, 1912	June 1, 1942.
Tilton, Capt. Wecome B.	Allendale, Mo.	June 3, 1884	Sept. 16, 1920.
<b>Civilian medical officers:</b>			
Barell, Harry	New York, N. Y.	July 16, 1904	Mar. 2, 1942.
Brewer, Frank Benton	Viola, Tenn.	June 7, 1894	Apr. 28, 1920.
Moyer, Ralph E.	Mountain Grove, Mo.	Oct. 11, 1895	Apr. 1, 1942.
Proffitt, Ray V.	Gunnison, Colo.	Aug. 27, 1889	May 29, 1919.
Williams, Harry B.	Rushville, N. Y.	Dec. 28, 1879	Feb. 1, 1920.
<b>Commissioned dental officers:</b>			
Archer, Maj. Isaac H.	Hancock County, Ga.	Nov. 15, 1887	Apr. 1, 1921.
Benway, First Lt. Emphy F.	Chicago, Ill.	Oct. 22, 1893	Mar. 15, 1937.
<b>Civilian dental officer:</b>			
Daugherty, Herbert D.	Nashville, Tenn.	Dec. 17, 1894	Apr. 12, 1937.

## OUTWOOD, KY.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Abel, Capt. Louis	New York City	Sept. 19, 1911	Mar. 16, 1942.
Berg, Capt. Lawrence E.	Red Wing, Minn.	Dec. 12, 1901	Dec. 1, 1941.
Lipton, Maj. Philip	Riga (Latvia), Russia	Dec. 2, 1909	Dec. 1, 1939.
Ross, Capt. Leon	New York City	Jan. 3, 1903	Feb. 2, 1942.
West, Maj. Elmer J.	Cloquet, Minn.	Aug. 10, 1899	Mar. 16, 1942.
Westfall, Capt. Marvin F.	Maryville, Mo.	June 21, 1907	July 8, 1940.
<b>Civilian Medical officers:</b>			
James, Samuel H.	Long Island, Ala.	Aug. 20, 1880	Apr. 1, 1920.
Kesterton, William J.	Mayfield, Ky.	May 31, 1885	Jan. 2, 1939.
Newman, Luther Byron	Helenwood, Tenn.	July 12, 1899	Apr. 27, 1944.
Thomas, Irl	Benton, Ky.	June 27, 1891	June 18, 1920.
Twente, Julius	Lafayette, Mo.	Mar. 10, 1899	Sept. 16, 1942.
<b>Commissioned dental officer:</b>			
Nixon, Capt. James W.	Wells, Minn.	Apr. 27, 1889	Sept. 16, 1940.

## PALO ALTO, CALIF.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Doan, Capt. Duiane I.	Goltry, Okla.	June 25, 1910	1941.
Hardgrove, Maj. Thomas J.	Tigerton, Wis.	Jan. 30, 1905	Mar. 13, 1935.
Thomas, Capt. Grace Fern	Gothenburg, Nebr.	Sept. 23, 1897	Apr. 1, 1944.
Weaber First Lt. Thomas H., Jr.	Allentown, Pa.	June 10, 1915	Aug. 2, 1943.
Wills, Maj. John Walter	Brookhaven, Miss.	Nov. 6, 1882	July 1, 1922.
<b>Civilian medical officers:</b>			
Carlisle, Chester L.	Columbus, Ohio	July 18, 1876	Feb. 15, 1920.
Defeo, Henry E.	Boston, Mass.	July 8, 1900	Nov. 1, 1939.
Douglass, William C.	Troy, N. C.	Apr. 27, 1886	Dec. 1, 1925.
Lasche, Percival G.	Milwaukee, Wis.	Feb. 21, 1875	Feb. 14, 1921.
Manley, Louis V.	Ackley, Iowa	Aug. 24, 1898	May 20, 1936.
<b>Commissioned dental officer:</b>			
McCrisis, Capt. William W.	Spencerville, Ohio	Jan. 12, 1887	Sept. 6, 1921.
<b>Civilian dental officer:</b>			
Talle, Otto S.	Starbuck, Minn.	Mar. 21, 1897	May 1, 1944.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## PERRY POINT, MD.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Clarke, Col. Harry G.	Toronto, Ohio	July 7, 1885	Jan. 11, 1924.
Hymowitz, Capt. Abraham	New York	Nov. 12, 1910	June 15, 1942.
McGreevy, Capt. Joan F.	O'Neill, Nebr.	Sept. 13, 1906	May 1, 1944.
Malinowski, Capt. Mitchell V.	No record available	June 12, 1913	Jan. 15, 1940.
Morrison, Maj. Benjamin G.	New York, N. Y.	Feb. 8, 1908	Nov. 1, 1938.
Nagler, Capt. Herman	Philadelphia, Pa.	Feb. 19, 1910	Mar. 1, 1943.
Steckler, Capt. Philip P.	New York City, N. Y.	Feb. 12, 1910	Feb. 2, 1942.
Trollinger, Lt. Col. Arvin E.	Hindsville, Ark.	Apr. 24, 1897	Jan. 15, 1935.
<b>Civilian medical officers:</b>			
Covalesky, Victor John	Forest City, Pa.	Mar. 13, 1913	Oct. 16, 1941.
Dolan, John E.	Kankakee, Ill.	Jan. 1, 1882	Oct. 30, 1931.
Smith, Lucian C.	Stafford, Va.	Nov. 29, 1875	Jan. 22, 1931.
Torrey, Eugene W.	Philadelphia, Pa.	July 4, 1893	Mar. 11, 1940.
<b>Civilian dental officers:</b>			
Lynch, George G.	Larchmont, N. Y.	May 11, 1897	Dec. 13, 1943.
Reed, Oscar R.	Labadie, Mo.	Feb. 16, 1887	Jan. 1, 1921.

## PHILADELPHIA, PA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officer:</b>			
Edwards, Maj. Thomson	Philadelphia, Pa.	Aug. 13, 1887	Mar. 1, 1921.
<b>Civilian medical officers:</b>			
Davis, William J. L.	Faterson, N. J.	Feb. 5, 1876	Mar. 26, 1945.
Diedrich, Vincent	Philadelphia, Pa.	July 15, 1889	Oct. 28, 1919.
Lewis, John F.	Scranton, Pa.	July 24, 1886	Feb. 1, 1944.
<b>Civilian dental officer:</b>			
Small, John J.	Philadelphia, Pa.	Sept. 15, 1892	Oct. 6, 1921.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Commissioned medical officer:</b>			
Leamus, Capt. Peter G.	No record available	Mar. 29, 1903	Feb. 9, 1944.
<b>Civilian medical officers:</b>			
Blew, Edgar M.	Bridgeton, N. J.	Mar. 27, 1882	Sept. 6, 1941.
Harvey, H. Brooks	Philadelphia, Pa.	Dec. 3, 1896	Jan. 13, 1944.
Laur, Leo J.	Sayre, Pa.	Dec. 27, 1894	Sept. 1, 1944.
Morales, Manuel G.	No record available	Aug. 13, 1890	Feb. 1, 1926.
Peterson, Thomas	Paterson, N. J.	Jan. 20, 1880	Apr. 18, 1921.
Riggin, George H.	Seaford, Del.	Apr. 7, 1879	Mar. 1, 1944.
Samuel, Meredith	Providence, Pa.	Aug. 29, 1875	Mar. 6, 1945.

## PITTSBURGH, PA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Golomb, Capt. Milton W.	No record available	Aug. 15, 1906	Dec. 17, 1943.
Lussier, Maj. Arthur H.	St. Rosalie, Canada	Jan. 18, 1897	Dec. 19, 1939.
McFadden, Maj. Harry W.	No record available	Oct. 15, 1888	Jan. 20, 1945.
Murphy, Capt. Samuel Alfred	do	May 9, 1889	Sept. 2, 1941.
Nathan, Capt. Louis	do	Oct. 11, 1902	June 1, 1942.
Yoder, Capt. Robert D.	do	Dec. 18, 1905	Feb. 23, 1944.
<b>Civilian medical officer:</b>			
Lauer, Cyril F.	Pittsburgh, Pa.	Apr. 22, 1889	July 19, 1944.
<b>Civilian dental officer:</b>			
Hayes, Lee W.	North Tonawanda, N. Y.	June 9, 1894	Dec. 1, 1930.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Commissioned medical officer:</b>			
Kretz, Capt. Stewart F.	Philadelphia, Pa.	July 5, 1908	Apr. 12, 1943.
<b>Civilian medical officers:</b>			
Edgar, Joseph C.	Coulterville, Ill.	Apr. 5, 1881	Mar. 13, 1944.
Menler, Carl J.	Sharon, Pa.	Oct. 31, 1882	Apr. 5, 1945.
Parker, Albert G.	Clairton, Pa.	Apr. 8, 1908	Apr. 10, 1944.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## PORTLAND, OREG.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Brown, Maj. James R.	Moss Point, Miss.	Feb. 3, 1907	Oct. 10, 1935.
Carter, Col. Paul I.	Hamilton, Va.	Aug. 28, 1885	Oct. 31, 1907.
Eisendorf, Capt. Lester H.	Chicago, Ill.	Mar. 4, 1914	Aug. 1, 1941.
Fowlkes, Capt. Everill Wm.	Butterville, Utah	Mar. 31, 1907	Nov. 1, 1939.
Gandin, Capt. Morris M.	Bachmut, Russia	Apr. 18, 1911	Dec. 1, 1939.
Green, Maj. Joseph S.	Philadelphia, Pa.	Apr. 23, 1903	Nov. 4, 1929.
Havlicek, Maj. Theodore L.	Verdigre, Nebr.	Sept. 10, 1902	Mar. 5, 1937.
Hyman, Maj. Milton D.	New York City	July 2, 1911	June 15, 1942.
Keller, Maj. George F.	Wisconsin	Dec. 24, 1899	May 4, 1931.
Maguire, Lt. Col. Leo M.	No record available	Aug. 22, 1888	May 1, 1922.
McClintic, Maj. James K.	Philipsburg, Pa.	July 6, 1891	May 1, 1931.
O'Toole, Capt. Arthur J.	Omaha, Nebr.	Oct. 16, 1907	June 25, 1937.
Owens, Capt. Guy E.	Norton, Kans.	Apr. 15, 1887	June 1, 1942.
Revell, Maj. Arthur J.	Scammon, Kans.	Aug. 5, 1904	Apr. 1, 1942.
Sherwin, Capt. Richard N.	Willamina, Oreg.	June 20, 1910	June 1, 1942.
Wolski, Capt. Joseph B., Jr.	Chicago, Ill.	May 1, 1911	Mar. 1, 1943.
<b>Civilian medical officers:</b>			
James, Ernest F.	Altoona, Pa.	May 1, 1874	Apr. 1, 1924.
Pfeiffer, George E.	Chicago, Ill.	Nov. 25, 1891	Nov. 26, 1920.
Williams, Michael	New York, N. Y.	July 8, 1906	Aug. 2, 1943.
<b>Commissioned dental officers:</b>			
Carson, Capt. Carlisle	St. Louis, Mo.	May 10, 1895	May 8, 1922.
Roloff, First Lt. Edwin H.	Maple Creek, Wis.	Dec. 12, 1905	Aug. 2, 1942.

## PROVIDENCE, R. I.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Cooper, Capt. Maurice Z.	Brooklyn, N. Y.	Feb. 19, 1905	May 1, 1936.
Speidel, Capt. Glenn P.	Iowa City, Iowa	Aug. 13, 1897	Apr. 13, 1937.
<b>Civilian medical officers:</b>			
Granata, Tancredi G.	New York, N. Y.	Apr. 11, 1891	Feb. 1, 1944.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officer:</b>			
Caldarone, Alfred	Providence, R. I.	Feb. 27, 1888	Oct. 24, 1921.

## RENO, NEV.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Blatt, Capt. Samuel E.	New York, N. Y.	Feb. 10, 1905	Dec. 2, 1940.
Seitz, Maj. Ira J.	Mandan, N. Dak.	Apr. 30, 1898	Oct. 1, 1931.
Winikow, Capt. William E.	Philadelphia, Pa.	June 4, 1907	July 8, 1940.

## ROANOKE, VA.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Adelman, Capt. Solomon	Brooklyn, N. Y.	Oct. 17, 1907	Aug. 1, 1941.
Cibelli, Maj. Louis A.	New York City	July 29, 1909	Oct. 3, 1938.
Des Rochers, Maj. Jean B.	Chicopee, Mass.	June 23, 1906	Feb. 2, 1937.
Faingold, Capt. Joseph E.	St. Paul, Minn.	Nov. 20, 1909	Jan. 15, 1940.
Gussion, Capt. Philip	New York	July 13, 1909	Do.
Hudgens, Lt. Col. John C.	Elberton, Ga.	Jan. 10, 1896	Apr. 14, 1925.
Laibstain, Capt. Herman	Norfolk, Va.	Jan. 26, 1913	Jan. 15, 1940.
Meyer, Maj. George I.	Pochahon, Ill.	Sept. 14, 1904	Dec. 10, 1934.
Oxman, Capt. Morris F.	Philadelphia, Pa.	Sept. 3, 1910	July 8, 1940.
Ransome, Maj. John T.	Hampton, Va.	June 21, 1893	Nov. 5, 1932.
Ross, Capt. Samuel H.	Philadelphia, Pa.	July 8, 1906	Mar. 2, 1942.
Zobel, Capt. Harold	Grodna, Russia	June 30, 1899	Mar. 16, 1942.
<b>Civilian medical officers:</b>			
Drake, Clifford	Tennessee	June 24, 1881	Nov. 20, 1928.
Pillar, Samuel	New York City	Oct. 19, 1899	Dec. 1, 1943.
Willong, Clavel T.	Glenville, W. Va.	Jan. 15, 1893	Sept. 18, 1919.
<b>Commissioned dental officer:</b>			
Nolan, Capt. James I.	No record available	July 4, 1886	Feb. 16, 1921.
<b>Civilian dental officer:</b>			
Fussell, George E.	Abbeville, Ga.	May 31, 1892	Mar. 1, 1930.

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## ROANOKE, VA.—Continued

Name	Place of birth	Date of birth	Date of appointment
ADJUDICATION ACTIVITIES			
Civilian medical officer: Boice, James M.....	Money More, Ireland.....	June 24, 1881	Mar. 15, 1945.

## ROSEBURG, OREG.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Cohenour, Maj. Robert E.....	Joliet, Ill.....	Sept. 21, 1913	May 1, 1941.
Pisetsky, Capt. Joseph E.....	New York City.....	Nov. 15, 1909	July 16, 1942.
Richardson, Lt. Col. W. F.....	Salem, Oreg.....	Feb. 1, 1894	Mar. 1, 1941.
Rosenblatt, Capt. Sidney.....	Brooklyn, N. Y.....	Dec. 14, 1907	Jan. 17, 1935.
Schaefer, Capt. Otto.....	Augsburg, Germany.....	May 5, 1909	July 16, 1942.
Civilian medical officers:			
Kinney, Kenneth M.....	Astoria, Oreg.....	Oct. 23, 1890	Nov. 23, 1927.
Kinney, George M.....	Camden, Miss.....	June 30, 1885	July 2, 1919.
Commissioned dental officer:			
Amiot, Capt. William F.....	Worcester, Mass.....	Mar. 16, 1890	Nov. 26, 1919.

## RUTLAND HEIGHTS, MASS.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Anderson, Capt. Nels. H.....	Marshalltown, Iowa.....	Sept. 26, 1907	Sept. 30, 1943.
Boral, Capt. Henry.....	Poland.....	Nov. 1, 1905	June 1, 1942.
Felderman, Capt. Jacob.....	Providence, R. I.....	Nov. 5, 1909	Feb. 23, 1938.
Gaines, Lt. Col. Justin E.....	Mussel Fork, Mo.....	Jan. 22, 1904	May 1, 1930.
Gilbert, Maj. Meyer M.....	Kuney, Russia.....	Nov. 10, 1889	Jan. 16, 1939.
Giventer, Capt. Max.....	Brooklyn, N. Y.....	Sept. 15, 1908	May 1, 1941.
Hechler, Capt. Robert.....	Springfield, Mass.....	June 13, 1908	Mar. 16, 1942.
Hoechstetter, Maj. Stanton S.....	Wilksburg, Pa.....	Mar. 1, 1904	July 28, 1930.
John, Maj. Ralph C.....	Lescott, Kans.....	Nov. 19, 1894	Oct. 28, 1935.
Kaplan, Maj. Rubin H.....	New York City.....	Feb. 27, 1907	Aug. 1, 1938.
Powers, Capt. Harry J.....	Brooklyn, N. Y.....	Jan. 16, 1890	Mar. 27, 1939.
Smerz, Capt. Anton.....	Chicago, Ill.....	June 13, 1910	Jan. 15, 1940.
Civilian medical officers:			
Hamlin, William E.....	Boston, Mass.....	Nov. 12, 1875	Nov. 10, 1920.
Rooney, John F.....	Worcester, Mass.....	Nov. 13, 1889	Mar. 16, 1935.
Wilson, John N.....	Landones, Md.....	Jan. 7, 1900	July 1, 1929.
Commissioned dental officer:			
Newton, First Lt. Bert W.....	Newell, Iowa.....	Dec. 25, 1895	Dec. 16, 1942.

## SALINA, KANS.

MEDICAL AND HOSPITAL SERVICE			
Civilian medical officer:			
Kenney, Clarence J.....	No record available.....	Jan. 13, 1882	Apr. 1, 1922.

## SALT LAKE CITY, UTAH

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Dovey, Maj. Edward G.....	Plattsburgh, Nebr.....	Nov. 23, 1890	May 1, 1930.
Humphrey, Capt. Norton R.....	Fairwater, Wis.....	July 13, 1913	Aug. 1, 1941.
Mendelson, Capt. Max M.....	Brooklyn, N. Y.....	Sept. 13, 1914	Feb. 2, 1942.
Roberts, Maj. Nathaniel E.....	Lebanon, Oreg.....	Mar. 30, 1888	Feb. 3, 1931.
Rosenberg, Capt. Harold.....	Bayonne, N. J.....	Dec. 3, 1912	May 1, 1941.
Winters, Maj. Allen C.....	Jacksonville, Fla.....	Mar. 28, 1907	July 5, 1938.
Civilian medical officers:			
Forbes, Harry B.....	Ogden, Utah.....	Oct. 29, 1877	Sept. 11, 1944.
Hinckley, Elmer E.....	Salt Lake City, Utah.....	Dec. 29, 1878	Feb. 16, 1945.
Knowles, Charles E.....	Springwater, N. Y.....	Oct. 12, 1898	July 8, 1940.
Commissioned dental officer:			
Snoddy, Capt. William H.....	La Junta, Colo.....	Dec. 22, 1894	Oct. 6, 1924.
ADJUDICATION ACTIVITIES			
Civilian medical officer:			
Hummer, Leo F.....	Iowa City, Iowa.....	Mar. 5, 1881	Jan. 7, 1944.



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## SAN FERNANDO, CALIF.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Bailey, Maj. Jesse L.	Bynum, N. C.	Jan. 11, 1905	Mar. 19, 1938.
Chandler, Maj. James B.	Madison County, Ga.	Nov. 1, 1903	July 3, 1934.
Disney, Maj. Edward K.	Coal Creek, Tenn.	Jan. 6, 1896	Dec. 20, 1940.
Hobson, Maj. Lewis C.	No record available	Jan. 15, 1886	Apr. 18, 1930.
Leverton, Lt. Col. William R.	Bowie, Tex.	Aug. 20, 1882	Nov. 9, 1928.
Malone, Capt. John T.	Louisville, Ky.	Oct. 10, 1880	Oct. 25, 1920.
Mapes, Maj. William D.	Pueblo, Colo.	Nov. 3, 1907	May 19, 1936.
Mensch, Capt. Saul A.	New York, N. Y.	Sept. 12, 1909	Feb. 3, 1941.
Scarborough, Capt. Dorothy L.	Caldo, Okla.	Apr. 1, 1901	Aug. 1, 1944.
<b>Civilian medical officers:</b>			
Crede, William H.	Chicago, Ill.	July 13, 1879	Apr. 1, 1921.
Damron, John E.	Union County, Ill.	Nov. 28, 1886	July 11, 1930.
Fatnsworth, David C.	Lincoln, Nebr.	June 5, 1882	July 1, 1920.
<b>Commissioned dental officer:</b>			
Bleasdale, Capt. John W.	Cleveland, Ohio.	July 25, 1891	July 6, 1922.

## SAN FRANCISCO, CALIF.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Berger, Maj. Max M.	Chicago, Ill.	Apr. 22, 1908	June 6, 1938.
Berk, Capt. Morris.	Kansas City, Mo.	June 2, 1912	Jan. 11, 1939.
Briscoe, Maj. Lance E.	Greenville, Ind.	Mar. 1, 1890	Dec. 31, 1924.
Creech, Maj. Clarence M.	Pacolet, S. C.	Mar. 16, 1903	Oct. 19, 1931.
Donnelly, Col. James G.	Paterson, N. J.	Apr. 8, 1890	Aug. 16, 1921.
Feldman, Capt. Sanford E.	San Francisco, Calif.	Apr. 20, 1914	Feb. 3, 1941.
Majka, Capt. Frank A.	Tacoma, Wash.	Apr. 19, 1910	Nov. 1, 1938.
Mann, Capt. Nathan.	Brooklyn, N. Y.	July 28, 1906	July 8, 1940.
Movitt, Capt. Eli Rodin.	Kiev, Russia.	Dec. 24, 1907	Nov. 1, 1939.
Schlosser, Capt. Joseph.	New York, N. Y.	Feb. 2, 1913	May 1, 1941.
Smith, Lt. Col. John V.	Independence, Iowa.	Apr. 22, 1907	Oct. 28, 1935.
Smith, Capt. Phillip B.	De Pere, Wis.	Mar. 9, 1912	Feb. 3, 1941.
Wilson, Maj. Ernest LeRoy.	Olmstedville, N. Y.	Apr. 22, 1888	July 16, 1925.
<b>Civilian medical officers:</b>			
Baxter, Geoffrey H.	Sebastopol, Calif.	Apr. 10, 1899	Mar. 2, 1931.
Chase, John S.	Denver, Colo.	Mar. 18, 1890	Oct. 20, 1934.
Coney, Rembert J.	Maysville, S. O.	Mar. 27, 1882	July 6, 1931.
Jillson, Walter A.	Orange, Mass.	Feb. 21, 1881	June 15, 1925.
Kaess, Andrew Joseph.	Vienna, Austria.	May 11, 1879	July 14, 1944.
Mitchell, Myron S.	City of Gaislin.	Feb. 24, 1890	Oct. 4, 1944.
Peace, Elber B.	Fort Norris, N. J.	Sept. 25, 1887	Mar. 27, 1922.
Weber, Manuel L.	Vobolnik, Russia.	Nov. 17, 1892	Nov. 20, 1930.
<b>Commissioned dental officers:</b>			
Single, Maj. Harry A.	Merrill, Wis.	June 8, 1893	Mar. 1, 1921.
Davis, Arthur L.	Mitchell, S. Dak.	Oct. 13, 1884	June 8, 1922.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Commissioned medical officer:</b>			
Bross, Capt. Samuel I.	Nikopol, Russia.	Aug. 11, 1889	Sept. 21, 1942.
<b>Civilian medical officers:</b>			
Ehlers, Reginald.	Newark, N. J.	Dec. 3, 1886	Sept. 21, 1944.
Baldwin, Anton.	Baltimore, Md.	Oct. 25, 1887	July 22, 1942.
Martin, John F.	Stonington, Conn.	Aug. 6, 1879	Aug. 15, 1921.
Swenson, Reuben.	Crookston, Minn.	Nov. 16, 1893	Apr. 30, 1941.

## SAN JUAN, P. R.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Campos Del Toro, Capt. Luis.	Puerto Rico.	Feb. 22, 1897	Dec. 1, 1938.
Serra-Chavarry, Maj. Jaime.	No record available.	Jan. 17, 1893	Jan. 2, 1929.

## SARATOGA SPRINGS, N. Y.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Pascal, Capt. Oscar.	Brooklyn, N. Y.	July 25, 1910	May 1, 1941.
Walsh, Maj. John S.	Sunderland, Mass.	Dec. 20, 1898	May 14, 1929.

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## SEATTLE, WASH.

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Appelman, Capt. Milton L.....	Brooklyn, N. Y.....	Aug. 3, 1909	Dec. 2, 1940.
Clayberg, Capt. Harold D.....	Chicago, Ill.....	Jan. 24, 1892	Mar. 16, 1942.
Ruben, Capt. Benjamin D.....	East Port Chester, Conn.....	Aug. 16, 1890	Feb. 10, 1941.
<b>Civilian medical officer:</b>			
Carey, Leland O.....	Palmyra, Iowa.....	Dec. 3, 1886	Dec. 5, 1928.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Caplan, Louis.....	Albany, N. Y.....	Feb. 7, 1900	May 28, 1942.
Capps, Paul G.....	Illioipolis, Ill.....	June 24, 1884	Dec. 11, 1944.
Wilkinson, Harry.....	Brooklyn, Iowa.....	Nov. 2, 1882	May 16, 1944.

## SHERIDAN, WYO.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Bennett, Maj. Edward R.....	No record available.....	Dec. 13, 1905	Feb. 1, 1937.
Glotfelty, Maj. James S.....	Batavia, Iowa.....	June 15, 1905	Apr. 2, 1937.
Mitchell, Maj. Henry S.....	Oakland, Md.....	Jan. 5, 1891	Oct. 30, 1930.
Robins, First Lt. Sol A.....	Bielostok, Poland.....	Nov. 12, 1902	Dec. 2, 1940.
Sterling, Lt. Col. Harold W.....	Duenweg, Mo.....	Sept. 26, 1903	Apr. 16, 1931.
Stewart, Capt. John H.....	San Antonio, Tex.....	Jan. 1, 1902	Feb. 3, 1941.
<b>Civilian medical officer:</b>			
St. Antoine, Henry.....	Burlington, Vt.....	Sept. 23, 1891	July 22, 1919.
<b>Commissioned dental officer:</b>			
Clark, Capt. Raymond J.....	Maryville, Mo.....	Aug. 5, 1895	May 1, 1930.

## SIOUX FALLS, S. DAK.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officer:</b>			
Cunningham, Capt. Robert S.....	Wheeling, W. Va.....	Jan. 31, 1907	Jan. 15, 1941.
<b>Civilian medical officer:</b>			
Vermeulen, Peter.....	Zeeland, Mich.....	Feb. 3, 1886	Oct. 4, 1922.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officer:</b>			
Rimer, Harold L.....	New York, N. Y.....	Jan. 15, 1910	Sept. 20, 1943.

## ST. CLOUD, MINN.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Kaplan, Capt. Samuel.....	Newark, N. J.....	July 26, 1916	Mar. 2, 1942.
King, Capt. Llewellyn H.....	Washington, D. C.....	Oct. 1, 1899	Feb. 28, 1938.
Klotz, Capt. Maurice.....	Belfast, Ireland.....	June 6, 1906	Sept. 13, 1937.
Kuitert, Maj. John H.....	Spring Lake, Mich.....	Aug. 28, 1908	July 8, 1940.
Passarella, Maj. Frank A.....	Chicago, Ill.....	Dec. 12, 1893	June 13, 1930.
Rosenbloom, Capt. William.....	Monessen, Pa.....	May 11, 1910	May 2, 1941.
Schrier, Capt. Harold L.....	New York, N. Y.....	Nov. 8, 1913	Mar. 2, 1942.
Wiggin, Maj. Dayton C.....	South New Market, N. H.....	July 18, 1882	Jan. 23, 1923.
<b>Civilian medical officers:</b>			
Davis, Charles F.....	Bethlehem, N. H.....	Oct. 6, 1886	Apr. 12, 1925.
Pringle, John A.....	Pittsfield, Ill.....	May 1, 1888	June 16, 1921.
Sharp, Earl.....	Waldo, Wis.....	Feb. 22, 1881	Do.
<b>Civilian dental officer:</b>			
Trainor, Aloysius J.....	Graceville, Minn.....	Mar. 9, 1892	Dec. 16, 1920.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## ST. LOUIS AREA OFFICE NO. 7

Name	Place of birth	Date of birth	Date of appointment
ADJUDICATION ACTIVITIES			
Civilian medical officers:			
Anderson, Frank	Springfield, Mo.	Oct. 25, 1896	Sept. 16, 1944.
Cashin, John E.	Montgomery, Ala.	Dec. 25, 1870	Jan. 18, 1944.
Gomien, Scott	Colfax, Ill.	Feb. 8, 1894	Dec. 17, 1923.
Kaminskas, Joseph T.	Chicago, Ill.	June 3, 1911	May 2, 1938.
O'Reilly, William	Alsey, Ill.	July 15, 1881	Mar. 6, 1944.
Sheahan, Edwin L.	St. Louis, Mo.	Aug. 10, 1882	Jan. 24, 1944.

## SUNMOUNT, N. Y.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Aronson, Capt. Abraham	Chicago, Ill.	June 2, 1911	June 2, 1938.
Crandall, Maj. Will G.	No record	Apr. 4, 1892	Sept. 1, 1930.
Doane, Capt. Edwin A.	Los Angeles, Calif.	July 18, 1906	June 15, 1942.
Durham, Maj. William R.	Maxeys, Ga.	Aug. 12, 1902	Dec. 18, 1934.
Gustafson, Capt. Carl J.	Sweden	Dec. 24, 1886	May 1, 1941.
Lipscomb, Col. Harold R.	Carrollton, Ga.	Oct. 21, 1894	June 4, 1921.
McHugh, Maj. John B.	Summit Hill, Pa.	Nov. 29, 1907	Nov. 1, 1939.
Schwartz, Capt. Louis	New York, N. Y.	Feb. 27, 1903	Aug. 1, 1941.
Walters, Lt. Col. Henry W.	Lincoln, Nebr.	June 26, 1908	Jan. 17, 1938.
Civilian medical officers:			
Byrne, Albert B.	Fort Thomas, Ky.	Sept. 9, 1893	July 19, 1944.
Crumrine, Leslie B.	Beallsville, Pa.	May 10, 1884	Jan. 2, 1931.
Harwood, Bruno S.	Plock, Poland	Jan. 1, 1880	June 1, 1944.
Purinton, Charles O.	New Hartford, Conn.	June 7, 1874	Oct. 29, 1920.
Scott, McClure	Reeiston, Va.	Nov. 13, 1876	Dec. 3, 1928.
Civilian dental officer:			
Park, Laurence	Stevens Point, Wis.	Aug. 13, 1890	Dec. 20, 1921.

## TOGUS, MAINE

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Balkin, Maj. Seymour S.	Russia	Mar. 31, 1911	Aug. 1, 1941.
Dachslager, Capt. Philip	New York, N. Y.	June 29, 1911	Nov. 2, 1942.
Dunn, Maj. Robert H.	Philadelphia, Pa.	June 16, 1907	June 17, 1935.
Gardner, Maj. William A.	St. Mary, La.	Jan. 20, 1887	Oct. 16, 1937.
Harris, Capt. Ralph N.	Pittsburgh, Pa.	June 22, 1907	Feb. 3, 1941.
Jump, Lt. Col. Clarence E.	Japan, Mo.	Nov. 1, 1902	Feb. 15, 1937.
Kaplan, Maj. Julius A.	Boston, Mass.	Nov. 1, 1898	Nov. 6, 1922.
Lipton, Maj. Sidney	New York, N. Y.	Dec. 21, 1913	Jan. 15, 1940.
Mazzola, Maj. Stephen	do	Dec. 26, 1906	Aug. 1, 1941.
Mountford, Lt. Col. Arthur H.	Salem, Mass.	Mar. 23, 1886	June 8, 1925.
Namlot, Capt. Charles	Russia	June 28, 1896	Feb. 2, 1942.
Newman, Capt. Benjamin	New York, N. Y.	June 20, 1915	June 1, 1942.
Schwartz, Capt. David	Austria-Hungary	Apr. 10, 1903	Do.
Staciva, Capt. Stanley J.	Kalisz, Poland	Apr. 10, 1905	Mar. 16, 1942.
Ventimiglia, Maj. William A.	New York, N. Y.	July 26, 1910	Jan. 6, 1941.
Weinstein, Capt. Sol	do	July 24, 1909	Mar. 2, 1942.
Civilian medical officer:			
Davis, Urey G.	Princeton, Ky.	Dec. 15, 1885	May 1, 1923.
Commissioned dental officer:			
Berliner, First Lt David	New York	Dec. 12, 1907	Oct. 9, 1941.
Civilian dental officer:			
Butterfield, Percy R.	Winterport, Maine	Sept. 23, 1899	Mar. 1, 1930.

## TUCSON, ARIZ.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Cameron, Maj. Lester	Picton, Canada	Aug. 1, 1894	July 8, 1931.
Drozda, Maj. Joseph P.	Omaha, Nebr.	Sept. 2, 1906	July 1, 1942.
Gipe, Capt. Walter W.	Connersville, Ind.	Aug. 16, 1884	May 22, 1944.
Greenbaum, Capt. Philip S.	New York, N. Y.	Aug. 2, 1908	July 8, 1940.
Gunter, Lt. Col. Roy A.	Canton, Ga.	July 22, 1886	Oct. 20, 1919.
McWhirt, Maj. Willis E.	Lampasas, Tex.	Sept. 23, 1884	July 4, 1920.
Siegel, Capt. Philip	Beacon, N. Y.	Nov. 18, 1909	Aug. 1, 1941.
Titche, Maj. Leon L.	Monroe, La.	Apr. 7, 1910	Feb. 20, 1941.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## TUCSON, ARIZ.—Continued

Name	Place of birth	Date of birth	Date of appointment
MEDICAL AND HOSPITAL SERVICE—CON.			
Civilian medical officer:			
Anderson, Carl A.....	Sweden.....	Jan. 28, 1879	Oct. 8, 1921.
Commissioned dental officer:			
Yohe, Capt. Perce P.....	Monongahela, Pa.....	Jan. 1, 1893	Nov. 15, 1920.
ADJUDICATION ACTIVITIES			
Civilian medical officer:			
Seibert, Alexander W.....	Illinois.....	Sept. 6, 1875	Aug. 6, 1919.

## TUSCALOOSA, ALA.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Aibel, Capt. Louis.....	Brooklyn, N. Y.....	Aug. 7, 1908	Nov. 2, 1942.
Byer, Capt. Louis.....	Manchester, England.....	Oct. 1, 1906	Mar. 16, 1942.
Center, Capt. Abraham H.....	Savannah, Ga.....	Mar. 7, 1905	Feb. 3, 1941.
Feldman, Capt. Raymond.....	Chicago, Ill.....	Oct. 27, 1909	July 17, 1939.
Ingram, Lt. Col. George H.....	Delta, Ala.....	Sept. 6, 1886	Jan. 15, 1923.
Johnson, Lt. Col. George L.....	Upson County, Ga.....	Apr. 13, 1882	Dec. 26, 1919.
Kahn, Capt. Edward.....	Chicago, Ill.....	July 7, 1914	Sept. 16, 1942.
Rackow, Capt. Leon L.....	New York City.....	Dec. 28, 1910	Feb. 3, 1941.
Rhodes, Maj. Gilbert A.....	New York, N. Y.....	Dec. 29, 1889	Feb. 27, 1930.
Roberts, Maj. Albert L.....	Gilbert, Miss.....	Oct. 11, 1888	July 1, 1922.
Solovay, Capt. Julius.....	Brooklyn, N. Y.....	Nov. 24, 1909	Feb. 24, 1936.
Commissioned dental officer:			
Tyler, Maj. Jesse M.....	Bogue Chitto, Miss.....	July 17, 1885	Nov. 17, 1920.

## TUSKEGEE, ALA.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Allen, Capt. Robert L.....	Barbados, British West Indies.....	Sept. 16, 1901	Dec. 28, 1931.
Parker, Maj. Prince P.....	do.....	Dec. 15, 1897	Oct. 8, 1924.
Branche, Lt. Col. George C.....	Louisburg, N. C.....	Jan. 10, 1896	Nov. 8, 1923.
Carter, Capt. Peter J.....	Franktown, Va.....	July 28, 1889	Mar. 30, 1925.
Davis, Maj. Harvey F.....	Chase City, Va.....	Aug. 22, 1896	Nov. 21, 1923.
Dibble, Col. Eugene H., Jr.....	Camden, S. C.....	Aug. 14, 1893	Feb. 16, 1936.
Dickson, Capt. Leon A.....	Portland, Maine.....	Oct. 17, 1913	Aug. 1, 1941.
Dwiggins, Maj. Horace G.....	Kansas City, Kans.....	Mar. 17, 1909	May 5, 1938.
Johnson, Maj. Simon O.....	McIntosh, Ga.....	Dec. 1, 1895	Oct. 30, 1923.
Kennedy, Capt. James A.....	Pine Bluff, Ark.....	Oct. 10, 1884	Dec. 18, 1926.
Kersey, Capt. George M.....	Richmond, Va.....	Aug. 2, 1911	Feb. 2, 1942.
Lewis, Capt. Willis E.....	Charleston, W. Va.....	May 14, 1898	Mar. 16, 1927.
Looney, Capt. Gordon C.....	Springfield, Mo.....	Dec. 21, 1904	Aug. 1, 1941.
Peters, Maj. Jesse J.....	Fort Wayne, Ind.....	Aug. 17, 1895	Nov. 1, 1926.
Pitts, Maj. Charles N.....	Bibb, Ga.....	Nov. 3, 1900	Jan. 4, 1932.
Richardson, Capt. Peter L.....	Charleston, S. C.....	May 5, 1898	Oct. 1, 1926.
Smith, Maj. Alan P.....	Topeka, Kans.....	Feb. 27, 1895	Aug. 16, 1927.
Taylor, Capt. Junius L.....	Newbern, N. C.....	Apr. 8, 1912	Feb. 2, 1942.
Tildon, Lt. Col. Toussaint T.....	Waxahachie, Tex.....	Apr. 5, 1893	Sept. 1, 1928.
Williams, Capt. Joshua W.....	Lightfoot, Va.....	Feb. 12, 1899	Feb. 21, 1938.
Civilian medical officers:			
Berry, Joseph A.....	Charleston, S. C.....	Aug. 4, 1895	June 1, 1942.
King, Drue.....	Augusta, Ga.....	Mar. 16, 1887	Oct. 22, 1923.
Lee, Edwin H.....	Seguin, Tex.....	Mar. 3, 1886	Feb. 2, 1931.
Mahone, Loniel A.....	Anniston, Ala.....	Mar. 16, 1894	May 1, 1930.
Commissioned dental officer:			
Davis, Capt. Thomas B.....	No record.....	July 3, 1885	Oct. 11, 1923.

## WACO, TEX.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Brannon, Maj. Earl P.....	Hastings, Okla.....	Sept. 28, 1908	June 1, 1938.
Crowell, Capt. Robert W.....	Galveston, Tex.....	Jan. 6, 1914	Mar. 16, 1942.
Friedman, Maj. Carl.....	New Jersey.....	Mar. 24, 1914	May 1, 1941.
Grossman, Maj. Maurice.....	Philadelphia, Pa.....	Dec. 5, 1907	Jan. 25, 1938.
Holmes, Lt. Col. Mansell B.....	Mount Vernon, Mo.....	Aug. 9, 1895	Jan. 26, 1927.
Lupo, Capt. Thomas G.....	New York City.....	May 7, 1910	May 1, 1941.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## WACO, TEX.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
<b>Commissioned medical officers—Con.</b>			
Marinacci, Capt. Alberto A.	Italy	Dec. 1, 1903	Feb. 3, 1941.
Rubin, Col. Harry	Waycross, Ga.	May 16, 1890	Apr. 1, 1921.
Watman, Lt. Col. Morris	Odessa, Russia	Aug. 21, 1905	Oct. 16, 1941.
<b>Civilian medical officers:</b>			
Gill, John L.	Rosedale, Mo.	Nov. 9, 1880	Feb. 18, 1925.
Laird, John S.	Newton County, Miss.	Jan. 24, 1882	Sept. 16, 1920.
McDaniel, John F.	Magnolia, Ark.	Aug. 18, 1896	Nov. 8, 1922.
Phillips, Warren M.	Newton, Ill.	Jan. 19, 1884	June 1, 1929.
Smith, Joseph G.	Groventon, Tex.	Sept. 20, 1881	Oct. 1, 1928.
<b>Commissioned dental officer:</b>			
Wyatt, Capt. Hamlette G.	Prices Branch, Mo.	Nov. 15, 1892	Dec. 15, 1921.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Commissioned medical officers:</b>			
Allison, Capt. Harold T.	Brookings, S. Dak.	Apr. 8, 1886	Apr. 30, 1942.
Price, Capt. Enoch C.	Waco, Tex.	Jan. 26, 1885	Apr. 1, 1944.
<b>Civilian medical officer:</b>			
Huddleston, William E.	Hayes County, Tex.	Dec. 25, 1891	Feb. 10, 1944.

## WADSWORTH, KANS.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Anderson, Capt. James O.	Lehi, Utah	Apr. 2, 1899	June 15, 1942.
Berger, Maj. Morley	Pittsburgh, Pa.	Nov. 3, 1905	Aug. 16, 1935.
Epstein, Capt. Benjamin	New York, N. Y.	Aug. 18, 1910	Mar. 2, 1942.
Ford, Maj. Harold V.	Kansas City, Mo.	Oct. 9, 1907	Feb. 18, 1935.
Freeman, Maj. William K.	San Augustine, Tex.	Dec. 31, 1904	Jan. 6, 1936.
Gellman, Capt. Milton B.	Philadelphia, Pa.	Sept. 27, 1912	Feb. 1, 1940; Mar. 2, 1944.
Glazer, Capt. Michael H.	Riga, Cowna County, Russia.	Oct. 20, 1892	Feb. 1, 1938.
Gross, Capt. Norman H.	New York, N. Y.	Feb. 13, 1911	Oct. 6, 1938.
Haynes, Capt. Harry J.	Alexandria, Va.	July 2, 1912	Nov. 1, 1939.
Hoberman, Capt. Morton	New York, N. Y.	Dec. 7, 1910	Feb. 3, 1941.
Hoge, Maj. Solomon F.	Waynesburg, Pa.	June 26, 1887	May 16, 1928.
Hohman, Maj. Louis M.	Cincinnati, Ohio	Feb. 8, 1896	Jan. 27, 1922.
Ingber, Capt. Nathan G.	Philadelphia, Pa.	Mar. 18, 1908	June 3, 1938.
Marshall, Maj. Malcolm Y.	Kentucky	Sept. 14, 1889	Jan. 5, 1931.
Mau, Capt. Walter	Riverdale, Ill.	Jan. 28, 1916	June 15, 1942.
Slavin, Capt. Manuel	Philadelphia, Pa.	Jan. 26, 1905	Dec. 2, 1940.
<b>Civilian medical officers:</b>			
Allee, Gail D.	High Point, Mo.	Aug. 7, 1876	Feb. 15, 1920.
Hunter, Matthew C.	Alto, Mich.	Feb. 1, 1890	Jan. 16, 1924.
Ward, Melgie	Georgia	Feb. 24, 1882	Dec. 6, 1920.
Williams, Frank Lee	Ellis, Kans.	Feb. 14, 1885	Aug. 21, 1919.
Yates, Albert S.	Groysen, Ky.	Apr. 17, 1893	July 8, 1940.
<b>Commissioned dental officers:</b>			
Fishman, Capt. Julius	New York City, N. Y.	Oct. 20, 1909	June 30, 1941.
Owen, Maj. Victor S.	West Virginia	June 1, 1898	May 1, 1922.
<b>Civilian dental officer:</b>			
Tate, Walla	Franklin County, Ill.	Dec. 8, 1893	June 26, 1940.

## WALLA WALLA, WASH.

<b>MEDICAL AND HOSPITAL SERVICE</b>			
<b>Commissioned medical officers:</b>			
Beatty, Lt. Col. Jesse J.	Rockport, Mo.	Feb. 15, 1886	Jan. 21, 1920.
Deagen, Capt. James R.	Bloomer, Wis.	Aug. 29, 1909	Nov. 1, 1939.
Feldman, Capt. Noah	New York City, N. Y.	Jan. 5, 1909	Feb. 3, 1941.
Jaffe, Maj. Bernard	Brooklyn, N. Y.	May 20, 1908	May 1, 1941.
Lloy, Capt. Anthony D.	Jersey City, N. J.	Aug. 21, 1899	Jan. 7, 1944.
Muirhead, Capt. Samuel John	Paciefce-Pernambuco, Brazil.	Feb. 11, 1913	May 1, 1944.
Smithson, Maj. Carl B.	Alva, Okla.	Aug. 11, 1895	Feb. 23, 1937.
Warner, Maj. Oliver M.	Evansville, Wis.	Dec. 31, 1898	Jan. 16, 1933.
<b>Civilian medical officers:</b>			
Jamieson, George	Devils Lake, S. Dak.	Oct. 2, 1889	Sept. 17, 1931.
Nather, Fred B.	Grayville, Ill.	June 6, 1882	Dec. 12, 1919.
Soderstrom, James C.	Malvern, Iowa	Jan. 22, 1905	Mar. 15, 1939.
<b>Civilian dental officer:</b>			
Hamilton, Robert	Chicago, Ill.	July 20, 1891	Apr. 22, 1930.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## WASHINGTON, D. C.

Name	Place of birth	Date of birth	Date of appointment
CENTRAL OFFICE			
MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Baird, Col. John H.	Newark, Ohio	Mar. 8, 1890	July 15, 1921.
Boswell, Lt. Col. John R.	Penfield, Ga.	June 14, 1898	Sept. 1, 1925.
Brooke, Lt. Col. Charles R.	Prince Georges County, Md.	Oct. 25, 1891	Oct. 1, 1920.
Cane, Lt. Col. Byron S.	Saranac, N. Y.	July 23, 1895	May 20, 1931.
Cook, Lt. Col. Frederick M.	Heidelberg, Miss.	Feb. 11, 1888	Jan. 21, 1924.
Culbertson, Lt. Col. William F.	Paola, Kans.	July 12, 1887	May 16, 1921.
Harding, Col. James C.	Chicago, Ill.	Feb. 20, 1893	Jan. 21, 1921.
Martin, Lt. Col. Earl A.	Tiffin, Ohio	Aug. 27, 1895	Oct. 1, 1928.
Melia, Col. Hugo	Indianapolis, Ind.	Feb. 26, 1888	July 1, 1925.
Mueller, Maj. Camillo F.	No record available	May 30, 1899	Aug. 26, 1939.
Murphy, Col. Dennis J.	do	Sept. 11, 1896	Jan. 9, 1921.
Rose, Col. Edwin J.	Cadmus, Ohio	June 9, 1884	June 15, 1920.
White, Col. Herman C.	Dallas, Pa.	Sept. 28, 1893	Sept. 20, 1920.
Wolford, Col. Roy A.	Piedmont, W. Va.	July 11, 1894	Aug. 1, 1920.
Yokley, Lt. Col. Charles W.	Baileytown, Tenn.	Dec. 17, 1893	May 10, 1920.
Civilian medical officers:			
Eastwood, Edmund	Greenwich, N. J.	Aug. 26, 1881	Oct. 22, 1941.
Farmer, Myron H.	Newnan, Ga.	Aug. 30, 1889	Oct. 29, 1930.
Griffith, Charles M.	Jasper, Minn.	May 22, 1882	July 28, 1919.
Wood, Clayton L.	Stanford, Conn.	Nov. 9, 1888	Feb. 23, 1922.
Commissioned dental officer:			
Trent, Lt. Col. Ralph W.	Leaksville, N. C.	Mar. 18, 1905	July 1, 1926.
Civilian dental officer:			
Beers, Lloyd Y.	Bath, Pa.	Nov. 22, 1886	Dec. 12, 1919.
Fowler, Milburn	Skowhegan, Maine	Sept. 21, 1891	May 16, 1920.
Gilliam, Paul S.	Crittenden, Va.	Apr. 5, 1888	Aug. 17, 1921.
ADJUDICATION ACTIVITIES			
<i>Veterans Claims Service</i>			
Commissioned medical officers:			
Brimmer, Maj. Karl W.	McCook, Nebr.	Jan. 18, 1893	May 15, 1944.
Crofton, Maj. George H.	Taunton, Mass.	July 4, 1888	Apr. 1, 1920.
Dembrow, Maj. William L.	Russia	May 28, 1889	July 1, 1918.
Drummond, Maj. Henry S.	Russellville, Ark.	Nov. 3, 1885	Apr. 1, 1931.
Johnston, Maj. Henry V.	No record available	May 16, 1883	Oct. 15, 1928.
Minthorn, Maj. Martin L.	Moorhead, Iowa	Nov. 6, 1895	Mar. 6, 1923.
Rider, Maj. Ernest B.	Morgan City, Iowa	Dec. 25, 1888	May 21, 1938.
Civilian medical officers:			
Ashley, Charles W.	Clinton, Ind.	Dec. 22, 1882	July 18, 1921.
Barry, Howard J.	Oregon, Wis.	July 28, 1879	May 18, 1925.
Brandenberger, E.	Milwaukee, Wis.	Apr. 11, 1887	July 12, 1921.
Conger, Jason H.	Brushton, N. Y.	July 15, 1887	Dec. 12, 1921.
Cook, Richard L.	Washington, D. C.	Nov. 5, 1878	Mar. 27, 1920.
Ditchburn, David	Barclay, Pa.	Apr. 26, 1878	Mar. 21, 1921.
Ernst, John R.	Louisburg, Kans.	Feb. 24, 1884	Feb. 20, 1930.
Fales, Ella Roy	Huntsville, Ala.	Aug. 9, 1874	Sept. 1, 1944.
Hall, Jesse L.	Smithwick, Kans.	Dec. 13, 1886	Sept. 16, 1920.
Howell, Dent H.	Marion, Ill.	Feb. 5, 1879	Mar. 1, 1921.
Israel, Isaac J.	Pittsburgh, Pa.	Aug. 20, 1885	Dec. 3, 1923.
Lancaster, George	LaPlata, Md.	Jan. 13, 1888	Dec. 1, 1930.
MacLain, Marshall	New Jersey	Jan. 23, 1890	Nov. 15, 1920.
Mehioph, Clarence W.	Dubuque, Iowa	Apr. 1, 1872	Jan. 3, 1944.
Shirkey, Ivy G.	Sissonville, W. Va.	Jan. 31, 1890	Apr. 16, 1925.
Thompson, Burton	Troy, Ind.	Dec. 29, 1885	Jan. 20, 1920.
Travers, Edgar E.	Cambridge, Md.	Feb. 5, 1885	Dec. 15, 1930.
<i>Board of Veterans Appeals</i>			
Commissioned medical officers:			
Clark, Lt. Col. Fred H.	Georgia	May 6, 1895	Aug. 3, 1920.
Gladning, Maj. Walter R.	New Church, Va.	June 28, 1898	Apr. 16, 1942.
Kimberly, Maj. David	No record available	Oct. 1, 1899	Mar. 19, 1942.
Koeh, Maj. Benno F.	LeRoy, Wis.	May 10, 1891	Jan. 15, 1921.
Ladd, Lt. Col. John M.	Petersburg, Va.	Jan. 25, 1891	Dec. 1, 1920.
Civilian medical officers:			
Brooks, Alexander	New York City	Jan. 19, 1886	July 20, 1921.
Caldwell, Bernie	Newcastle, Va.	Dec. 22, 1877	Dec. 1, 1919.
Cooper, Edwin H.	Findlay, Ohio	Jan. 12, 1878	Mar. 22, 1920.
Fisher, E. Moore	Chester, England	Nov. 2, 1875	Nov. 1, 1919.
Foxwell, Raymond	Leonardtownton, Md.	Dec. 20, 1891	Feb. 8, 1926 to June 30, 1941; Nov. 3, 1943.
Gilchrist, Edgar	Wolfeburg, Pa. (employee on extended sick leave).	Nov. 13, 1879	Sept. 16, 1904.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

WASHINGTON, D. C.—Con.

Name	Place of birth	Date of birth	Date of appointment
CENTRAL OFFICE—Continued			
ADJUDICATION ACTIVITIES—CON.			
<i>Board of Veterans Appeals—Con.</i>			
Civilian medical officers—Contd.			
Groover, Gordon	Savannah, Ga.	Feb. 24, 1892	Apr. 1, 1931.
Nelson, John	Nebraska	Jan. 15, 1884	Aug. 1, 1920.
Smith, D. O.	Derby, Iowa	Mar. 24, 1881	June 27, 1918 to May 15, 1919; Sept. 16, 1920.
<i>Insurance Claims Council</i>			
Commissioned medical officers:			
Cavanaugh, Maj. Leo M.	Cumberland, Md.	July 6, 1888	Dec. 5, 1921.
Knott, Maj. William L.	Washington, D. C.	Jan. 18, 1909	July 2, 1937.
Leonard, Maj. Edward A.	Philadelphia, Pa.	Oct. 8, 1893	May 26, 1920.
Schroeder, Maj. Leo P.	Calumet, Mich.	Sept. 13, 1889	Aug. 29, 1921.
Stewart, Col. Harrison M.	North Adams, Mass.	May 16, 1888	May 27, 1922.
Stretch, Maj. Clarence M.	No record available	Mar. 4, 1893	Nov. 27, 1939.
Trecase, Maj. Joseph P.	Butler, Pa.	Sept. 29, 1898	Dec. 22, 1930.
Yost, Maj. Ernest L.	No record available	Mar. 30, 1891	Jan. 17, 1944.
Civilian medical officers:			
Drew, Henry C.	Baltimore, Md.	Apr. 5, 1887	Feb. 1, 1920, to Aug. 30, 1922; Oct. 16, 1922.
Heffner, William J.	Springfield, Mass.	May 23, 1879	Mar. 5, 1919.
Kneedler, Harry	Collinsville, Ill.	Sept. 23, 1870	Mar. 27, 1944.
McDermott, Bernard A.	Philadelphia, Pa.	June 19, 1884	Oct. 16, 1924.
Osterhaus, Karl	Norfolk, Va.	Mar. 7, 1882	Dec. 1, 1919.
Thompson, Ralph	Springfield, Ohio	Sept. 14, 1894	Feb. 15, 1945.
Villaroman, Isabelo R.	San Rafael, Bulacan, Philippines.	July 8, 1909	Sept. 14, 1944.
MOUNT ALTO			
MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Bacon, Lt. Col. Frank S.	Minneapolis, Minn.	Jan. 12, 1906	Nov. 16, 1931.
Beardsley, Col. Lewis G.	Bridgewater, Conn.	Dec. 27, 1888	Mar. 1, 1921.
Bersack, Maj. Solomon R.	Ukmerge, Lithuania	Feb. 3, 1908	Jan. 15, 1940.
Blumenthal, Maj. Basil	New York, N. Y.	Nov. 23, 1909	Aug. 15, 1938.
De Angelis, Maj. Carmelo E.	do	June 29, 1911	May 1, 1941.
Eisner, Capt. Cyrus I.	do	Mar. 27, 1908	Feb. 3, 1941.
Feinstein, Capt. Harold R.	do	Oct. 17, 1912	Mar. 16, 1942.
Finek, Capt. Harold Y.	Jersey City, N. J.	July 2, 1914	Aug. 1, 1941.
Goebel, Lt. Col. Clarence J.	Hartington, Nebr.	Oct. 16, 1900	Oct. 7, 1930.
Goldberg, Maj. Herbert A.	New York, N. Y.	May 7, 1909	Feb. 14, 1936.
Haynes, Lt. Col. Grady O.	Gate City, Va.	Oct. 31, 1895	Sept. 3, 1924.
Kauffman, Maj. William P.	Port Jervis, N. Y.	June 24, 1904	Oct. 1, 1938.
Kessler, Maj. Israel	Philadelphia, Pa.	Sept. 18, 1908	Mar. 22, 1937.
Levatin, Capt. Paul	Boston, Mass.	July 14, 1913	Feb. 2, 1942.
Lindsay, Capt. Merrill K.	Topeka, Kans.	May 20, 1884	Feb. 7, 1944.
Nesbitt, Maj. John W.	Sycamore, Ill.	Mar. 19, 1908	Feb. 7, 1937.
Paul, Capt. Norman	Russia	Apr. 14, 1901	Dec. 1, 1941.
Perkins, Maj. Hanson T.	Springfield, Md.	Aug. 26, 1899	Sept. 1, 1925.
Pettengill, Maj. Warren M.	Haverhill, Mass.	Feb. 23, 1894	Mar. 30, 1931.
Resta, Maj. George A.	Louisville, Ky.	Dec. 23, 1904	Sept. 16, 1931.
Taylor, Capt. Ingram C.	Milo, Iowa	Oct. 7, 1904	July 8, 1940.
Traum, Maj. Aaron H.	Fort Morgan, Colo.	Mar. 22, 1907	Jan. 4, 1935.
Weinberg, Capt. Benjamin A.	Chicago, Ill.	Apr. 17, 1914	Aug. 1, 1941.
Civilian medical officers:			
Barshop, Maurice M.	Baltimore, Md.	Dec. 25, 1889	Nov. 24, 1928.
Giltner, Harry A.	New Washington, Ind.	Nov. 6, 1878	Apr. 25, 1944.
Gunion, John Paul	Washington, D. C.	Sept. 15, 1876	Aug. 25, 1921.
Lacy, Justin E.	Bedford County, Tenn.	Oct. 18, 1878	Feb. 1, 1921.
Commissioned dental officer:			
Lanier, Maj. William D.	Birmingham, Ala.	Feb. 24, 1889	Sept. 26, 1919.
REGIONAL OFFICE			
MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Byington, Maj. Samuel B.	Charlestown, W. Va.	Nov. 29, 1886	Oct. 19, 1921.
Meade, Maj. Spencer V.	New York, N. Y.	July 19, 1904	June 14, 1938.
Reichard, Maj. Morris	Hungary	Sept. 9, 1881	Feb. 28, 1924.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## WAUKESHA, WIS.

Name	Place of birth	Date of birth	Date of appointment
MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Garment, Maj. Edward M.	Boston, Mass.	Dec. 10, 1905	Apr. 8, 1937.
Johnson, Maj. Herbert L.	Willacoochee, Ga.	Nov. 2, 1891	Apr. 1, 1927.
Kellam, Maj. John W.	Pungoteague, Va.	Nov. 2, 1890	May 1922.
Kimber, Maj. Karl E.	Clark County, Ohio	Jan. 3, 1907	Sept. 28, 1940.
Civilian medical officers:			
Asper, Guy P.	York Springs, Pa.	Apr. 17, 1880	July 15, 1921.
Carlin, Seymour	Brooklyn, N. Y.	Mar. 21, 1912	Mar. 16, 1942.
Cassidy, Franklin	Charlestown, Miss.	Nov. 24, 1886	June 1, 1921.
Darius, Dean J.	Athens, Greece	Aug. 2, 1908	Oct. 17, 1944.
Civilian dental officer:			
Glicklich, Isadore	Stepan, Russia	Feb. 15, 1896	Mar. 23, 1931.

## WEST ROXBURY, MASS.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Baxley, Lt. Col. Haughton W.	Baltimore, Md.	Apr. 22, 1896	Feb. 18, 1922.
Cassell, Capt. Edward F., Jr.	Nieliose, Mass.	June 30, 1911	Aug. 1, 1941.
Dalton, Maj. Stephan J.	Marlboro, Mass.	Nov. 4, 1894	Nov. 1, 1920.
Imburgia, Maj. Frank J.	Akron, Ohio	Jan. 8, 1907	Feb. 2, 1937.
Livingston, Lt. Col. Stanton K.	Wilbraham, Mass.	Apr. 10, 1898	Dec. 22, 1930.
McLaughlin, Maj. Joseph H.	Whitman, Mass.	Sept. 30, 1893	Feb. 11, 1939.
Rudman, Maj. Benjamin W.	Hartland, Maine	Dec. 2, 1892	Aug. 20, 1920.
Salwen, Maj. Robert	Brooklyn, N. Y.	Nov. 3, 1911	Feb. 1, 1940.
Shahon, Maj. Henry I.	Aydin, Turkey	Apr. 16, 1896	May 2, 1941.
Simonetti, First Lt. Louis J.	Capriati al Volturno, Italy	Mar. 17, 1906	Mar. 1, 1943.
Stein, Maj. Tobias	Zelva, Poland	Sept. 10, 1906	Jan. 21, 1939.
Toltz, Capt. Julius B.	Drinsk, Russia	Sept. 25, 1899	Mar. 16, 1942.
Civilian medical officers:			
Sorkin, Joseph J.	Russia	Mar. 2, 1893	Feb. 2, 1937.
Tartakoff, Samuel	Boston, Mass.	Oct. 2, 1899	Jan. 12, 1925.
Commissioned dental officer:			
Kadison, Capt. Charles G.	New York, N. Y.	Jan. 1, 1900	July 11, 1938.
Civilian dental officer:			
Delaney, Henry A.	Bronx, N. Y.	Aug. 17, 1888	June 7, 1924.
ADJUDICATION ACTIVITIES			
Civilian medical officers:			
Medalia, David B.	Moscow, Russia	Dec. 12, 1888	Jan. 17, 1944.
Moran, Andrew C.	Manville, R. I.	Apr. 27, 1890	Oct. 1, 1920.
Sharry, Charles F.	Somerville, Mass.	Sept. 23, 1886	Oct. 4, 1944.

## WHIPPLE, ARIZ.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Hornyak, Maj. William J.	Philadelphia, Pa.	June 23, 1909	Oct. 16, 1939.
Reed, Maj. Ernest Corydon	Wichita, Kans.	Nov. 7, 1894	Oct. 23, 1930.
Weinstein, Maj. Selig B.	Stepan, Poland	June 10, 1910	Nov. 1, 1939.
Civilian medical officers:			
Brann, Harold	Roland, Ill.	May 28, 1884	Dec. 15, 1920.
Daniel, Grover C.	Olloville, Ky.	Nov. 24, 1891	July 11, 1919.
Fahy, John E.	Philadelphia, Pa.	Sept. 22, 1876	Apr. 15, 1920.
McCreary, Marcellus	Evergreen, Ala.	Apr. 12, 1874	May 1, 1944.
McKenna, Harold	Montgomery, Minn.	June 1, 1898	Aug. 23, 1930.
Robins, Seymour	New York, N. Y.	Sept. 15, 1908	May 10, 1943.
Wilkiemeyer, Fred	Newport, Ky.	Sept. 7, 1879	Sept. 16, 1925.
Commissioned dental officer:			
Kettner, Capt. Eugene C.	Trinidad, Colo.	Oct. 17, 1895	Feb. 1, 1921.

*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

## WHITE RIVER JUNCTION, VT.

Name	Place of birth	Date of birth	Date of appointment
MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Birnbaum, Maj. Leo.....	New York City.....	Aug. 20, 1894	Jan. 15, 1935.
Cooper, Maj. Philip.....	Boston.....	Nov. 11, 1908	Feb. 3, 1941.
Levitt, Capt. Harry.....	New York City.....	Jan. 8, 1904	Mar. 16, 1942.
Warsawsky, Maj. Harry.....	Brooklyn, N. Y.....	July 5, 1909	Feb. 16, 1937.
Weiss, Capt. Andor A.....	Czechoslovakia (now Hungary)	June 14, 1906	Dec. 1, 1939.
Weissberg, Capt. Jonas.....	New York City.....	Dec. 16, 1909	Nov. 2, 1942.
Civilian medical officers:			
Levy, Emanuel.....	Chicago, Ill.....	Nov. 30, 1886	Apr. 1, 1920.
Salomonsky, G. H.....	Richmond, Va.....	Mar. 12, 1903	Jan. 11, 1935.
Commissioned dental officers:			
Sawyer, Capt. Bertram H.....	Melrose, Mass.....	July 5, 1894	Apr. 15, 1922.

## WICHITA, KANS.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Fitzgerald, Maj. Edward M.....	Pine Island, Minn.....	Aug. 29, 1904	May 1, 1936.
Hinkle, Maj. Warren L.....	Bigelow, Mo.....	Dec. 2, 1895	Feb. 1, 1939.
Paye, Maj. Philip H.....	Grosse Pointe, Mich.....	Sept. 14, 1909	May 1, 1941.
Pearce, Lt. Col. Albert R.....	Michigan.....	Oct. 27, 1888	Nov. 1, 1921.
Zerlin, Capt. Isidore.....	Brooklyn, N. Y.....	Apr. 11, 1909	Jan. 4, 1939.
Civilian medical officers:			
Curtis, Howard C.....	De Kalb County, Tenn.....	Dec. 6, 1881	Jan. 31, 1925.
Purves, George K.....	Tracy, Minn.....	Oct. 22, 1874	Nov. 1, 1944.
Shelly, Hargus G.....	Mulvane, Kans.....	Nov. 18, 1881	June 1, 1922.
Commissioned dental officers:			
Blais, Capt. Otto R.....	Duluth, Minn.....	Nov. 2, 1894	Feb. 2, 1925.
ADJUDICATION ACTIVITIES			
Civilian medical officers:			
Boland, Frank W.....	Walnut, Iowa.....	June 4, 1882	Jan. 16, 1944.

## WOOD, WIS.

MEDICAL AND HOSPITAL SERVICE			
Commissioned medical officers:			
Adashek, Capt. William H.....	Milwaukee, Wis.....	Jan. 25, 1911	Nov. 1, 1939.
Bensman, Capt. Louis L.....	Peoria, Ill.....	Apr. 7, 1912	Dec. 1, 1941.
Berger, Capt. Louis M.....	Chicago, Ill.....	Aug. 18, 1908	Feb. 23, 1937.
Bresnahan, Lt. Col. John F.....	Boston, Mass.....	Dec. 18, 1881	Jan. 29, 1931.
Coon, Capt. William L.....	Denison, Iowa.....	Sept. 27, 1906	Oct. 10, 1938.
Dimond, Maj. Edgar A.....	Lamar, Mo.....	Sept. 30, 1912	Oct. 17, 1939.
Fairall, Capt. Emmett R.....	Kidder, Mo.....	Mar. 29, 1892	Apr. 1, 1942.
Falk, Capt. Victor S.....	Stoughton, Wis.....	Mar. 4, 1889	Apr. 17, 1944.
Feingold, Capt. Philip P.....	Russia.....	Aug. 4, 1899	Dec. 5, 1940.
Fritz, Capt. William H.....	Sioux Falls, S. Dak.....	Nov. 28, 1907	July 1, 1942.
Golkin, Maj. James.....	Russia.....	Apr. 21, 1908	Jan. 18, 1939.
Jansen, Capt. Harold G.....	Albany, N. Y.....	Nov. 8, 1889	Apr. 1, 1942.
Liberman, Maj. David L.....	Brooklyn, N. Y.....	Nov. 4, 1893	May 1, 1924.
McKie, Capt. John F.....	Near Northboro, Iowa.....	Sept. 4, 1882	Apr. 1, 1944.
Mullins, Lt. Col. Glenn.....	Douglas County, Ga.....	Apr. 2, 1892	Nov. 27, 1931.
Primakow, Capt. Max J.....	Milwaukee, Wis.....	Oct. 12, 1906	Jan. 25, 1935.
Rhea, Maj. Clarence W.....	Forney, Tex.....	Sept. 22, 1890	Apr. 1, 1921.
Sagi, Capt. Joseph H.....	Penbrook, Pa.....	Aug. 8, 1912	Nov. 1, 1939.
Sanelippo, Capt. Anthony J.....	Milwaukee, Wis.....	Mar. 23, 1913	Mar. 1, 1943.
Schaeffer, Capt. Bernard S.....	do.....	Feb. 4, 1914	Jan. 15, 1940.
Shirley, Maj. Amos R.....	England.....	May 12, 1887	Mar. 10, 1920.
Slaney, Lt. Col. John G.....	Richland County, Wis.....	Mar. 23, 1901	Mar. 8, 1932.
Slaybaugh, Maj. James C.....	Milwaukee, Wis.....	Aug. 30, 1907	May 23, 1936.
Stein, Maj. William.....	Jersey City, N. J.....	Jan. 19, 1906	Mar. 3, 1938.
Szymanski, Capt. Stanley R.....	Erie, Pa.....	July 1, 1912	June 15, 1942.
Trepagnier, Capt. Francis B.....	Chicago, Ill.....	May 29, 1905	Aug. 1, 1941.
Vogl, Maj. Henry L.....	South Milwaukee, Wis.....	Apr. 13, 1906	Aug. 26, 1941.



*Veterans' Administration commissioned and civilian doctors and dentists—Con.*

WOOD, WIS.—Continued

Name	Place of birth	Date of birth	Date of appointment
<b>MEDICAL AND HOSPITAL SERVICE—CON.</b>			
<b>Civilian medical officers:</b>			
Alpert, Henry R.....	New York, N. Y.....	Apr. 13, 1907	Feb. 3, 1941.
Artman, Edward L.....	Philadelphia, Pa.....	July 2, 1891	Mar. 14, 1938.
Guilbert, Gerald D.....	Yam Hill, Oreg.....	Mar. 24, 1896	Sept. 3, 1936.
Kristjanson, Hjordleifur T.....	Thyngayalsysla, Iceland.....	Mar. 18, 1876	Apr. 17, 1944.
Liefert, William C.....	Milwaukee, Wis.....	Aug. 22, 1885	June 1, 1920.
Mabrecklein, Arthur G.....	do.....	Sept. 29, 1878	Mar. 16, 1944.
McLaughlin, William J.....	Templeton, Wis.....	Apr. 29, 1885	Oct. 5, 1944.
Meyst, Charles H.....	Glencoe, Minn.....	Feb. 9, 1876	Nov. 1, 1919.
Orban, Louis C.....	Budapest, Hungary.....	Apr. 11, 1889	Apr. 24, 1944.
Parks, Charles William.....	Lincoln, Nebr.....	June 20, 1888	Oct. 20, 1930.
Schlomovitz, Benjamin H.....	Milwaukee, Wis.....	May 18, 1889	May 1, 1923.
Sutherland, Justin.....	Sylvester, Wis.....	Dec. 15, 1875	Sept. 11, 1944.
Thomas, Clyde O.....	Elizabeth, Ill.....	Feb. 24, 1906	Mar. 16, 1945.
Wilson, Richard S.....	Harrison County, Ky.....	Oct. 22, 1905	Oct. 2, 1939.
Wolff, Morris.....	Muncie, Ind.....	June 30, 1879	Mar. 1, 1921.
Woodward, William T.....	Democrat, N. C.....	Feb. 8, 1883	Aug. 16, 1944.
<b>Commissioned dental officer:</b>			
Eggena, Maj. Paul H.....	Monticello, Minn.....	Aug. 25, 1890	Mar. 13, 1920.
<b>Civilian dental officers:</b>			
Baker, Roy H.....	Girard, Kans.....	Jan. 15, 1890	Mar. 11, 1922.
Clark, Alexander.....	No record available.....	Apr. 25, 1896	May 15, 1944.
<b>ADJUDICATION ACTIVITIES</b>			
<b>Civilian medical officers:</b>			
Burke, Charles H.....	New Hampton, Iowa.....	Dec. 12, 1884	Jan. 26, 1931.
Froede, Herbert.....	Milwaukee, Wis.....	Apr. 28, 1895	Jan. 18, 1944.
Kenney, Joseph F.....	Delavan, Wis.....	Mar. 28, 1886	Jan. 10, 1944.
Lang, Richard J.....	No record available.....	May 8, 1900	July 1, 1930.
Weed, Linton G.....	Oshkosh, Wis.....	Oct. 27, 1894	May 1, 1941.

NOTE 1.—All the physicians in the employ of the Veterans' Administration had a civil-service status before being commissioned. Those not commissioned still have such status. A few of the physicians were originally acquired by transfer from the U. S. Public Health Service, or the Indian Service in the early years of the Veterans' Administration. (Limited personnel precludes searching individual files for this data.)

NOTE 2.—(a) Those shown as commissioned officers were commissioned in the Army or Navy and immediately "detailed" to duty with the Veterans' Administration. All of those listed were employees of the Veterans' Administration at the date of commission.

(b) Data is not available in the Veterans' Administration as to Army or Navy officers detailed to the Veterans' Administration other than those mentioned in paragraph (a). It would require individual surveys by the War or Navy Departments to obtain that data. The delay and use of personnel precludes including it in this tabulation.

Now the committee will go into executive session.

(Whereupon, at 4 p. m., the committee went into executive session.)

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INVESTIGATION OF THE VETERANS' ADMINISTRATION, WITH  
A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY  
OF THE ADMINISTRATION AND OPERATION OF  
VETERANS' ADMINISTRATION FACILITIES

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HEARINGS  
BEFORE THE  
COMMITTEE ON WORLD WAR VETERANS'  
LEGISLATION

HOUSE OF REPRESENTATIVES  
SEVENTY-NINTH CONGRESS

FIRST SESSION

PURSUANT TO

**H. Res. 192**  
(79th Congress, 1st Session)

A RESOLUTION TO DIRECT THE COMMITTEE ON  
WORLD WAR VETERANS' LEGISLATION TO  
INVESTIGATE THE VETERANS'  
ADMINISTRATION

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**PART 7**

APRIL 13, MAY 12, JULY 20, 21, 24, SEPTEMBER 20,  
OCTOBER 4, 15, 1945

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## COMMITTEE ON WORLD WAR VETERANS' LEGISLATION

### SEVENTY-NINTH CONGRESS

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82 DEC 2 1945

## INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY OF THE ADMINISTRATION AND OPERA- TION OF VETERANS' ADMINISTRATION FACILITIES

The report of the Honorable Charles W. Vursell on the inspection of veterans' facilities at Danville, Downey, Dwight, Marion, and Hines, Ill., is placed in the record of this investigation by order of the chairman of the Committee on World War Veterans' Legislation.

APRIL 13, 1945.

Congressman JOHN E. RANKIN and

MEMBERS WORLD WAR VETERANS' LEGISLATION COMMITTEE,  
*House Office Building, Washington, D. C.*

GENTLEMEN: I desire to make a report of my inspection of the veterans' hospital at Marion, Ill., on April 6, 1945.

This hospital, at that time, contained 179 patients. The hospital has 210 beds up now, and has room for only 4 additional beds when needed. Its staff consisted of the following:

Physicians: 8 ward physicians, 1 clinical director, and 1 full-time physician on extended sick leave.

Nurses: 1 chief nurse, 1 surgical nurse, and 21 staff nurses.

Attendants: 26 in all.

You will note that there seems to be a sufficient number of nurses, physicians, and attendants. In fact, I was told that they are always able to procure plenty of laborer attendants. They do not complain as having had any real difficulty in the procurement of nurses or physicians.

You will also note, by the number of patients, that the hospital is not overloaded at this time. The management tries to keep about 10 vacant beds for emergencies. The type of patients are general, medical, and surgery. About 85 percent are World War I veterans, and 10 to 15 percent are veterans of the present war. The turn-over is big with the average stay of a patient being about 30 days. They discharge about as many each month as come in.

Dr. E. A. Welch, managing director, after a conference in his office, turned me over to Lieutenant Colonel Shawber, clinical director, who has been with the Veterans' Administration for 10 years. With Colonel Shawber, I went through the institution from top to bottom.

This hospital is modern, having been built in 1942. Colonel Shawber said they had all of the modern equipment they need, and I was impressed with the facilities of the clinic and their operating rooms and staff. Heading the staff of surgeons is Major Navin, who has been with the Veterans' Administration about 10 years.

I was also impressed with the managing director, Dr. E. A. Welch. He appears to be a man who knows his business, and one who has managerial ability and is deeply interested in his work.

In going through the wards, I found clean linens, comfortable beds, and everyone with whom I had occasion to speak was apparently well satisfied.

I would hardly know how it would be possible for the building, from the front office through the halls and the wards, to be kept in better shape. It was immaculately clean. The kitchen and dining room are exceptional in equipment and in its service to the patients. The food is excellent and well prepared. I am attaching to my report a menu, which I think is exceptional.

There is little doubt but that this hospital will be greatly overloaded for several years in the future. It is my opinion, because of the wide territory it will serve, that its expansion by building on to the east and west wings should have most serious consideration by the Veterans' Administration. There should be provided, in my judgment, such extension capable of adding 250 extra beds to the institution. When the building was constructed, extensions were anticipated to the extent that the light plant, boiler rooms, lighting cables, water mains, and sewerage were all installed to carry a 500-bed load. For this reason, such an extension could be made at a minimum of cost. If and when such addition should be undertaken, such new construction, in my judgment, should provide for officer's quarters and also some additional recreational facilities.

In summing up, it is my judgment that this institution is in capable hands and is being well directed by Dr. Welch and his associates in the interest of the veterans.

Sincerely yours,

C. W. VURSELL, M. C.

*Weekly regular diet menu, Veterans' Administration facility, Marion, Ill., week beginning April 2, 1945*

MONDAY, APRIL 2, 1945

WEDNESDAY, APRIL 4, 1945

Breakfast:

Stewed prunes.  
Puffed wheat.  
Broiled bacon.  
Toast, butter.  
Coffee, milk.

Dinner:

Broiled liver.  
Fried onions.  
Candied sweet potatoes.  
Pineapple apricot cobbler.  
Bread, butter.  
Coffee, milk.

Supper:

Hot cakes, syrup.  
Broiled sausages.  
Lettuce with french dressing.  
Blackberry sauce.  
Bread, butter.  
Coffee, milk.

TUESDAY, APRIL 3, 1945

Breakfast:

Chilled grapefruit.  
Whole-wheat meal.  
Scrambled eggs.  
Toast, butter.  
Coffee, milk.

Dinner:

Broiled steak.  
French fried potatoes.  
Buttered spinach.  
Bread Pudding.  
Bread, butter.  
Coffee, milk.

Supper:

Fried side pork.  
Black-eyed peas.  
Sliced onions.  
Fruit jello with cream.  
Biscuit, butter, jelly.  
Coffee, milk.

Breakfast:

Fruit juice.  
Cherioats.  
Hot cakes, syrup.  
Toast, butter.  
Coffee, milk.

Dinner:

Baked ham, mustard.  
Baked potatoes.  
Buttered cabbage.  
Maple mold.  
Bread, butter.  
Coffee, milk.

Supper:

Spaghetti with Spanish sauce.  
Cold cuts.  
Fruit salad.  
Ice cream.  
Bread, butter.  
Coffee, milk.

THURSDAY, APRIL 5, 1945

Breakfast:

Stewed apricots.  
Wheat-cream meal.  
Fried eggs.  
Toast, butter.  
Coffee, milk.

Dinner:

Boiled beef with vegetable.  
Lettuce with french dressing.  
Plum sauce.  
Crackling cornbread, butter.  
Coffee, milk.

Supper:

Hamburgers.  
Buttered corn.  
Pickle and lettuce wedges.  
Apple Betty.  
Buns, butter.  
Coffee, milk.



*Weekly regular diet menu, Veterans' Administration facility, Marion, Ill., week beginning April 2, 1945—Continued*

FRIDAY, APRIL 6, 1945

## Breakfast:

Chilled grapefruit.  
Rice Krispies.  
French toast, sirup.  
Toast, butter.  
Coffee, milk.

## Dinner:

Braised fish with tartare sauce.  
Creamed potatoes.  
Buttered lima beans.  
Pumpkin pie.  
Bread, butter.  
Coffee, milk.

## Supper:

Grilled omelet.  
American fried potatoes.  
Pickled egg and beet salad.  
Ice cream.  
Bread, butter.  
Coffee, milk.

SATURDAY, APRIL 7, 1945

## Breakfast:

Oranges.  
Oatmeal.  
Soft-cooked eggs.  
Toast, butter.  
Coffee, milk.

## Dinner:

Braised frankfurters.  
Steamed potatoes.  
Sauerkraut.

Submitted by:

Approved:

SATURDAY, APRIL 7, 1945—continued

## Dinner—Continued

Cottage pudding.  
Buns, butter.  
Coffee, milk.

## Supper:

Baked beans.  
Boston brown bread, butter.  
Sliced cheese.  
Sliced onion in vinegar.  
Apricot sauce.  
Coffee, milk.

SUNDAY, APRIL 8, 1945

## Breakfast:

Bananas.  
Bran flakes.  
Broiled bacon.  
Toast, butter.  
Coffee, milk.

## Dinner:

Roast chicken and dressing.  
Mashed potatoes, gravy.  
String beans.  
Butterscotch sundae.  
Hot rolls, butter.  
Coffee, milk.

## Supper:

Vegetable soup and crax.  
Assorted sandwiches.  
Creamed peas.  
Cottage cheese salad.  
Fruit cup.  
Coffee, milk.

\_\_\_\_\_, *Chief Dietician.*\_\_\_\_\_, *Chief Medical Officer.*E. A. WELCH., *Manager.*

MAY 12, 1945.

Congressman JOHN E. RANKIN and  
MEMBERS, WORLD WAR VETERANS' LEGISLATION COMMITTEE,  
*House Office Building, Washington, D. C.*

GENTLEMEN: Pursuant to your request that I make a personal investigation of the Hines Hospital in Chicago I hereby submit my report to the Veterans' Committee of the Seventy-ninth Congress.

On Monday, May 7, 1945, I called upon the managing director, Mr. Charles D. Beck, who, after a conference in his office, called in chief medical director, Dr. Warren A. Colton, with whom I went through the institution, first inspecting the food storage rooms, the kitchen, and baking equipment. I had a conference with the chief dietitian on their facilities for preparing food. I must admit, from a standpoint of sanitation, preparation, and the serving of warm food to the patients, it is apparent that little, if any, improvement is desirable, or could be recommended.

I also went through the surgical, clinical, X-ray, and laboratory departments and questioned Dr. Colton as to whether these facilities were adequate and up to the high standard necessary to care for the patients of the institution. It

appeared, from the information he gave me, that there was little, if any, new or modern equipment that should be added at this time. I also went through the dental laboratory and drug department, finding both adequate and in good shape. In going through the different wards, I found them clean and in a satisfactory, sanitary condition with regard to floors, bed linen, etc.

I was impressed with their recreational hall and facilities. I am informed that veterans and civic organizations of Chicago cooperate generously in furnishing entertainment which, added to the movies shown by the institution, furnish some sort of entertainment for the patients almost every day or night during the week.

I talked with Dr. Colton about outside consultants and asked him for the names of such consultants. I am including herewith the names and background of such consultants for the benefit of the committee. He informs me there are now 22 such consultants fully cooperating with the medical staff of the hospital and, from what information I was able to get from him as to the type of cooperation they give, and the background of these men, I am much impressed with the splendid cooperation apparently existing.

After going through the various wards, talking with a number of the physicians and the patients, and observing the work and treatment they are giving, I am firmly of the opinion that their medical staff, assisted by the outside consultants, are rendering a satisfactory service to the patients of the hospital.

This is a large institution. At the present time, they have 1,708 patients of which about 26 percent are veterans of the present World War II. The other 74 percent are veterans of the Spanish-American War and World War I. Their full bed capacity is 1,925. They do not try to operate at over 92 percent of capacity, holding 8 percent reserve in vacancies.

I am informed their nurse ratio, by reason of student cadet nurses helping out, is satisfactory at the present time and that the outgo of patients is about equal to those coming in.

Their chief help problem has been in their inability to secure a sufficient number of hospital attendants, by reason of the fact men and women who are qualified for such work can make more money in war plants. I find their wage scale for attendants is only \$126 per month without any subsistence allowed, that they are all hired through civil service, or rather are hired and blanketed into civil service. Dr. Colton said they had made a request to the Veterans' Bureau at Washington for permission to upgrade attendants in the amount of \$10 per month, that they had asked the War Manpower Commission for a higher referral priority, that the same had been promised, but their request has not as yet been granted. They say the granting of such request would help materially in securing attendants.

At this hospital, they take care of 12 different types of surgery cases. A few NP patients are accepted temporarily, but are passed on to other hospitals. Treatment for veterans of almost every type is provided. At this point I want to refer to the tuberculosis ward. As I recall, there was something like 250 patients, the majority of them World War I veterans. I spent sometime talking with Dr. Arnold Shamaskin, chief of tuberculosis service, and with other doctors, after having gone through the ward. It is my belief that the physicians in charge are competent and are rendering a satisfactory service. In this connection I want to attach a copy of a letter with charts in which Dr. Shamaskin discusses the treatment of tuberculosis patients and the results obtained, as compared with other private hospitals. Inasmuch as one of the newspaper articles directed some criticism at this particular work at the Hines Hospital, I believe members of the committee will find this information of particular interest.

For the benefit of the committee, I am also attaching a personnel background experience of the outside consultants who are rendering an active and splendid service to the institution. I am also filing a list of personnel now employed at the hospital.

Also, I am filing a very interesting census concerning the dietetic section of this hospital, with menus showing special diets for special cases, and the general menu through April and May. I particularly want to call the attention of the committee to the splendid dietetic program which is being carried out in the institution.

By way of summary, I may say that from my inspection and observation of the Hines Hospital, it is my opinion that the morale of the personnel and of the patients is at least satisfactory. By this I mean the physicians, nurses, and those coming in close contact with the patients seem to be interested and enthusiastic about their work. Naturally, the morale of patients is bound to be

below normal, but from my observations it is my opinion that the patients generally feel they are receiving satisfactory treatment. Naturally in an institution of this kind, there will be complaints, some of which are justified. Doubtless, there could be some improvements made which do not appear to one making an inspection of the institution.

Sincerely yours,

C. W. VURSELL, M. C.

SEPTEMBER 20, 1945.

In re inspection of veterans' facilities at Danville, Downey, and Dwight, Ill.

HON. JOHN E. RANKIN,

*Chairman, World War Veterans Legislation Committee,  
Washington, D. C.*

MY DEAR SIR: Pursuant to your request to inspect veterans' facilities during the congressional recess, I beg leave to report on the above-mentioned hospitals.

On August 10, 1945, I inspected the veterans' facility at Danville, Ill., which is in charge of Dr. George A. Rowland and his subordinates.

This is an NP facility with a capacity of about 2,300. Dr. Rowland, I find to be an exceptionally capable man who, for many years, has been with the Veterans' Administration.

Dr. Rowland informs me they are having exceptional success with the use of the shock treatment. The hospital has a fair supply of doctors and nurses and was not overcrowded with patients at that time.

Sanitary conditions were excellent. Food preparation and serving was very satisfactory. The clinical department is adequate.

In my judgment, this is one of the best operated hospitals in the Midwest due largely to the great interest taken in his work by Dr. Rowland.

On August 11, 1945, I made an inspection of the facility at Downey, Ill., which is in charge of Col. Delmar Goode.

This hospital was built a number of years ago and is not up to the standard to lend itself in all departments to the work being done. They had sufficient beds and the general situation was improved by the completion of an addition some 4 months ago taking care of about 600 patients.

With some slight exceptions the clinical equipment was regarded by those in charge as sufficient. The clinical director, Lt. A. Rodriguez, who has been with the Veterans' Administration since 1919, as well as Colonel Goode, impressed me as being men who are deeply interested in their work and who put the welfare and treatment of the veterans first. It is my opinion they are doing a splendid job in the direction of this institution.

Downey is an NP hospital and they praise most high the results they are obtaining by the use of shock treatment. They state they are giving such treatment to about 30 patients a day.

Their greatest trouble has been in securing competent attendants by reason of the fact that Downey is located almost in the Chicago metropolitan area which throws them in competition with higher labor standards for more desirable work in the area. They have a sufficient number of physicians and also of nurses.

I had the opportunity of observing the quantity and type of food served, being there during the lunch hour, and found no fault with the preparation, quantity, or quality.

This institution, I would say, is being well conducted under present conditions and equipment.

On August 13 I inspected the hospital at Dwight, Ill., in charge of Lt. Col. W. E. Kendall.

This is a small institution doing general hospital work with a capacity of only 200 patients and I found they have an average of about 125 patients a day. I am informed it has never been overcrowded. About 70 percent of the patients are World War I veterans and about 30 percent of the patients are World War II veterans.

I went through the institution with clinical director, Dr. S. T. Taylor who has working under him about 6 Army physicians and approximately 15 nurses.

The building is splendid with lots of sunlight and open air. It is extremely well equipped from the standpoint of clinical appliances.

The sanitary condition is excellent from top to bottom and I regard it as well managed and not lacking for anything necessary to the treatment of its patients.

Respectfully submitted.

C. W. VURSELL, M. C.



By direction of the chairman of the Committee on World War Veterans' Legislation there is placed in the record the proceedings of this committee held at Wood and Milwaukee, Wis., by the Honorable James Domengeaux, a subcommittee of this committee.

PROCEEDINGS OF PUBLIC HEARING IN RE VETERANS' ADMINISTRATION  
FACILITY AT WOOD, WIS.

(Held at Wood and Milwaukee, Wis., July 20, 21, and 24, 1945)

WOOD, WIS., *July 20, 1945.*

FRIDAY MORNING SESSION

The public hearing conducted by the World War Veterans' Legislative Committee of the Congress of the United States, in the auditorium of the Veterans' Administration facility at Wood, Wis., Friday and Saturday, July 20 and 21, 1945, was called to order at 10 a. m. by the Honorable James Domengeaux, Congressman from Louisiana.

Congressman DOMENGEAUX. Ladies and gentlemen, will the meeting come to order?

Congress, as you know, authorized some 3 months ago the investigation of the Veterans' Administration. This was brought about because of certain charges and criticisms that had been made from time to time in the press and in magazines throughout the country criticizing certain practices existing in these veterans' hospitals. Congress delegated the investigation of these charges to the Veterans' Committee of Congress, of which I am a member, and since this investigation has started this committee in Washington and elsewhere has been investigating these conditions.

I was sent by the committee to inspect and investigate hospitals in Wisconsin and Minnesota, and that is the reason I am here this morning. For the past 2 days I have had the opportunity of visiting your hospital, talking to some of the patients, and seeing generally the way things are operated at Wood.

Now, this is going to be a very informal hearing. What we are interested in is to find out the facts and the truth. We will necessarily have to be governed, however, by the usual and simple rules of evidence. I am going to expect the witness to testify to facts within his own knowledge and not indulge in hearsay evidence that he may have heard from a third party or a third person. I feel that anyone who has a grievance, anyone who has criticism to make should be given that opportunity; as well as those who feel they have been treated properly, decently, and with consideration, those also we would like to hear.

I read in one of the Milwaukee papers yesterday, where some reference was made about this investigation, that some of the patients at Wood felt that the truth could not be gotten to because the officials

of the hospital would be present at these hearings. Well, necessarily, they should be present, and they are here at my request, because this is an open hearing and everyone interested should be present and should have opportunity to speak.

I want to assure, however, any patient who may be present today that he can speak with complete freedom, without any fear whatsoever of reprisals, because I feel, as well as Congress, that if there exists a condition in these hospitals where one who may be in disagreement with the management would have reprisals visited against him if he happened to disagree or to be in disapproval with their policy, that would be an intolerable condition. I have seen no evidence of such a condition existing at the Wood hospital, or at the five other hospitals that I have visited throughout the country. I think that a man can come up and express himself without any fear whatsoever of endangering his future position or relations with the veterans' facility. And I do want to make this statement: That in the event anything developed of this nature after I have left, I would appreciate that patient contacting me and I will call it to the attention of Congress, and I assure you that any official or other person who attempts to take it out upon you for testifying will not be an employee of the veterans' facility for long.

Now, I want to invite anyone in this audience who cares to contribute something to this investigation to come forward. We all realize that the problem in caring for the veterans of this war is one of the most serious ones that confront this country. We in Congress feel, as well as this gracious Nation and grateful Nation, that the veteran, particularly the one who has service connections, is entitled to everything that a grateful country can do for that veteran. And these soldiers who are returning in such great numbers from World War II, when they do return, should be given the opportunity to receive the very best medical attention and hospital care that science and medicine can provide, and money. Now, if this investigation will contribute to bringing about such a condition, I think much good will be done.

Now, if anyone wants to come up and testify I will be glad to listen to him.

LEE ROY MAYALL, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman Domengeaux:

Q. What is your name, sir?—A. My name is Lee Roy Mayall.

Q. What is your residence?—A. I have no residence. I was born and raised in the State of Iowa. I am a transient veteran and I have no home. I travel from place to place. They claim I have a home in this institution if I want to stay here.

Q. I think so.—A. But the conditions did not suit myself, so I have traveled considerable and tried to work to make my living. But I did have 75 percent disability up to the first day of July 1933, when the Economy Act was enacted. Since that time I have had no connection with the pension from the United States Government. But the most of my grievance would not only be to this hospital, but other hospitals in general.

Q. I would be very glad to get your impression, but let's restrict ourselves to Wood, if possible.—A. Yes, sir. This includes Wood, as well as the rest of it.

Q. Yes. Because that is our job at the present time. Are you a veteran of World War I?—A. World War I. I have here a statement. I wrote Frank T. Hines before Hines was out. I wrote his office in Washington, D. C., trying to obtain dentures which these boys, or us old men, could not obtain from the United States Government.

Q. Trying to obtain what?—A. Dentures, which has caused the bad condition in my stomach.

Q. You are not a doctor?—A. I was in with a bad stomach, and they claim that I had no acid in my stomach. I thought the food had consumed the acid. Not being able to masticate the food properly—

Q. How long ago was that, sir?—A. That was last winter, the one I wrote and the answer I got.

Q. You never did have—A. I did.

Q. Your teeth?—A. Absolutely, and I have signed two affidavits to the effect of what became of the teeth that I obtained from the United States Government, and they were ratified and I was supposed to get teeth, but they made it so inconvenient to me when I stayed there at two different institutions.

Q. Where was that?—A. Boise, Idaho, and Biloxi, Miss. I am a resident, as I said—supposed to be—of Iowa.

Q. Yes, sir.—A. Now I came into Wood.

Q. Have you got your teeth now?—A. I was informed yesterday by the dentist that he could recommend teeth, but then after I—he said the ward surgeon would have to approve it. I say the ward surgeon. The ward surgeon was saying that I am eligible for domiciliary care over here, which I don't want. The reason I don't want it, I can make a living if I can keep my stomach in condition where I can. I think I am better out of an institution than I am in it.

Q. Certainly, if any man can make a living he should do so.—A. That is right. Now they tell me that I cannot obtain teeth until I get the domiciliary care; I can't get them out of the hospital, although my teeth were pulled here in 1936 in Wood, Wis., pulled in this institution on account of the stomach condition. Now, they don't realize that my stomach condition still exists, and the teeth I had obtained from them were broken and lost, which I signed a sworn affidavit to the effect, but they don't seem to realize that I am not in the same condition I was in 1936 when they pulled my teeth. They think my stomach is much better, or something, or they want me to go to domiciliary care to get those teeth, which I don't think is justifiable.

Q. How long have you been at Wood?—A. I have been here about 10 days now, but I have been to see the dental clinic. The dental clinic is the only clinic I have been to here.

Q. You have been here 10 days?—A. Yes, sir; maybe more than that. I came in a week ago last Tuesday.

Q. What is your main objection, that there has been too much delay?—A. The main objection is that I cannot obtain teeth unless I go



to domiciliary care. They want to shove me over here in the company, and under those conditions you do have to work 5 days a week, supposedly. You have 2 days' company detail, and you have 3 days that you work on outside detail, which makes 5 days in the week that you work over here.

Q. In the home?—A. Around the grounds, in the home—grounds generally. You might be in this hospital. You don't know where you will be, wherever they want to detail you. You might be in the laundry. But I have always thought they should keep a man that is eligible, if he has a good discharge—eligible to go out and obtain a job and go to work and earn his own living, without working over here for board and clothing. And I still think that I should be entitled to that. If I was set up with what I need, which I am entitled to, I could go out among the public and obtain lots of jobs, with one eye to complain on that. If I had a glass eye, they wouldn't complain because they would think I had two. Glasses—I can't get those without going to domiciliary care. There is another thing. In fact, if I did do as this institution, or any other that I know of, has rules and regulations—

Q. Those are sometimes necessary.—A. I would stay in these institutions maybe 2½ or 3 months before I could get out to go to work for anybody. And, of course, in the wintertime I can't stand the outside elements of the weather.

Q. Is there any reason or logic to the fact that you should go into the domiciliary home to get this service? You are not ill, are you? I mean you are not ill so that the hospital would be the proper place for you? There may be a reason for that situation.—A. Domiciliary isn't the proper place for me, either. If I am able to go out and work, I think I should be allowed to obtain the necessities that would keep me in a condition so that I can work on the outside, instead of going over here.

Q. I will tell you what we will do. There may be some reasons for that. That is not too fundamental and not too serious, but to you it is very important and you are entitled to get that relief.—A. It would be important to many a veteran besides me, these boys coming out now.

Congressman DOMENGEAUX. I am going to ask if the manager or one of his officials may have an explanation for this particular case.

The WITNESS. My record is clear. They forced me a lot of times to get it down here, but I am clear now. There is no reason why I haven't the right to teeth. They were pulled in here.

Congressman DOMENGEAUX. Are you gentlemen familiar with this veteran's case?

Lieutenant Colonel MULLINS. No, I am not, sir.

In cases similar to which this appears, if a man is not in need of active hospitalization and he is in need of some dental appliance, or any other appliance, and he is eligible to go over to the home, he is usually transferred over there to make active hospital beds, which are urgently needed, available.

The WITNESS. My hospital condition has never been cleared up in this institution, and I thought I could obtain my teeth. I came here under arthritis.

By Congressman DOMENGEAUX:

Q. What objection do you have to going into the home and getting this service done, and make it possible for one of these beds in the hospital that may be very much needed to become available?—A. I have no objections to getting out of the hospital. Since this has been brought up it would be better for me, because conditions would be made so rough for me I couldn't stay here anyway. They showed there has been—I left two institutions and signed two affidavits. They told me they would give me teeth. I had to get out of the veterans. I had pretty near given up being a veteran of the First World War on account of it.

Q. Do you mean to tell me, sir, that because of your maybe testifying to the fact that you are insisting on what you believe your rights to be, which you should, that they are going to make it so disagreeable for you that you are going to have to leave? Who is going to do that?—A. In this open conference where we have only a few minutes, if I could relate a few things that has happened to me in Wood, Wis., which we haven't time to go in and discuss, I could show you many a reason why I would have to leave here.

Q. We will take the time.—A. It is quite alternative. I came in here according to the rules and regulations of the Veterans'—

Q. Don't quote the law. Give me the facts and names.—A. The fact is that I had obtained clothing out of Bath, N. Y., and I obtained—that was under an emergency—which is not transferable from one institution to another. Then I had obtained clothing in Dayton, Ohio, which was under another emergency, which was not transferable to no institution, but when they came in here and asked me I told them the truth, yes, I had obtained the clothing. I had one suit of clothing on, but they charged me with two suits. They didn't—this was under Colonel Pearsall. They wouldn't issue me no clothing until after I had did a dump. That is so many days' work out here on the dump. My feet was on the ground. There was snow on the ground; it was cold. I didn't have adequate underwear to protect me from the elements of the weather. We won't relate the law, because you said we wouldn't go into the law.

Q. There is such a difference of opinion as to what the law is.—A. In Public Order No. 2—if you know Public Order No. 2, that covers the law. Public Order No. 2 said they must furnish me with that extra clothing to protect me from the elements of the weather and keep me in a sanitary condition in this institution or any other institution. The fact was I didn't have them, and weren't issued. The captain of the guard said, "You do your dump and we will issue the clothing afterward." It did bring on a state of bad cough. I have bronchitis. It is bad.

Q. Who is the captain of the guard that deprived you?—A. He is gone now; he was relieved.

Q. Why?—A. By the influence of O. K. Marshall, a Government inspector—relieved him of his duties over here at the guard.

Q. For doing things like he did to you?—A. The manager wasn't able to take care of the clothing slips himself, and he turned it over to the captain of the guard, which was not permissible among the Veterans' Administration. But it happened. He gave them to the captain of the guards and the captain of the guards was running it.

Anybody had to obtain clothing and did not have in their possession—they had so many days dump to do. We were supposed to be allowed \$156 of clothing a month.

Q. A month?—A. I mean a year. During my trial over here on the clothing allowance I happened to bring up the fact and I said 158, and the colonel said, "No, 156." I said, "I haven't used 156 of clothing here. Why should I be put on the dump to work for something I am still entitled to?" But that didn't settle the case. He said "You will do the dump if you stay here." I said, "There isn't any law to compel me to stay here. If you will allow me to come out of this court right now, I will leave this barracks, and it will be some time since I come," which it has been 6 years since I came back. But the fact was I didn't get clothing until O. K. Marshall, the inspector, came here, Government inspector.

Q. Had you complained to the manager about this?—A. I did. Major Froemming was the man that wrote me the order for the clothing. I asked the manager during my trial why it was that he as manager had to turn the clothing slips over to the captain of the guards and allow him to transact his business, instead of transacting it himself. They thought I was drunk; gave me 30 more days and said, "You were drunk."

Q. Thirty days more?—A. Thirty days more dump. That made 86 days I had all told. I didn't think I could do the 86 days out in the cold. Naturally, I left the institution. It has been 6 years since I came back to the institution. All the time they have been telling me, "You go to Wood, Wis., where you had your teeth out." I am in Wood, and now they say I have to go to domiciliary to get my teeth. "You are entitled to them at Wood; not here." Now, when the Government pulls my teeth on account of a stomach condition, I didn't see why it wouldn't be they could issue—these hospitals. These boys may not be in Wood, Wis., all the time. They don't belong here, all of them. I think they should be able to obtain those teeth in any part of the country they go to.

Congressman DOMENGEAUX. Is there any regulation that a man has to go back to the hospital where the teeth were extracted to get new teeth?

Lieutenant Colonel MULLINS. No; there is no regulation on that. If teeth are removed in one of our hospitals and that man goes into some other hospital for a prolonged period of treatment, they will clear that dental status. They will write in here to get his record and fix his teeth. But if he is not in need of prolonged hospitalization, they will not do that unless he is in a place like this where he can be sent into domiciliary treatment.

The WITNESS. Will you kindly read that to the office? It was up to the institution I was hospitalized in that they should give me teeth. I am here, without teeth now. It is going to be a public meeting.

By Congressman DOMENGEAUX:

Q. If you want to make this a part of the record—A. The first letter, too. They fairly investigated my case and found I should have the teeth.

Q. We will make them both a part of the record. Have you anything else?—A. I haven't been in—Major Froemming; he is more than a major now since he got to be manager. He was assistant manager.



I was here when he was assistant manager. This is the first time I have come back in 6 years.

Q. Do you know of evidence of brutality or mistreatment now?—A. I never saw no brutality in this institution, not unless—not since I have been here this time. The only time before, I thought it was a little to put a man out without shoes in slush and snow, and protect him—without adequate clothing, I draw 75 disability under allowance—

Q. This man who was responsible for that was dismissed from this hospital?—A. Not the entire institution. I wouldn't call that man—he was only just a common, ordinary man working as captain of the guard. If he turned the deal over to him, which it shouldn't be—a manager who can't manage his own institution should not be a manager. [Applause.] Turn it over to a man that is simply captain of the guards and say, "Here, you take the clothing slips and do what you want to with them."

Q. You have to delegate authority.—A. Coming down to authority, you have manager, assistant manager; you have the domiciliary officer, you have captain of the company, and captain of the guards. You have them all the way down. But it still passes down to the smallest man in rank, finally, they have got, and give it to the captain of the guards and tell him to "do what you want."

Q. Supposing you were manager of this institution, do you think you could run it by yourself?—A. If I had that many understudies under them I believe one of them would know enough without me going to the bottom to the captain of the guards. [Applause.] I honestly believe I wouldn't have to go down to him.

Q. That is a matter of discretion.—A. Discretion? Not discretion.

Major FROEMMING. May I clarify a few points?

Congressman DOMENGEAUX. Yes, of course.

Major FROEMMING. In the first place, we never had a chief guard in this facility. The name of our present guard is Leo Schreier. He was preceded by a gentleman whose name was C. W. Mooney. Mr. Mooney was retired after many years of faithful service. There are no charges pending against him, or ever preferred against him.

With reference to the clothing charges, a man that is short clothing is very carefully tried by either the manager or assistant manager, and all the facts are developed and disposition is made right there. No part of that trial or disposition is left to the chief guard. The trial is in writing, and this gentleman's case, with a full record of all court procedures in his case, are available for inspection.

The WITNESS. Pardon me, Major. Would it be possible for me to ask you if Captain Mooney, the chief guard, did not have the clothing slips and he was making everybody do dump? In fact, you were the one that issued the order I could get clothing at that time. This doesn't pertain to what I am complaining about, my teeth. This would be something that was for the boys coming in here today. I would like to see them get a break, even if we didn't. [Applause.]

Major FROEMMING. Any member that has lost his clothing or left them behind in some boarding house and cannot bring them back so that they may be properly inspected and condemned if no longer serviceable, must either pay for that clothing or work it out, and after the decision has been made by either the manager or the assistant manager as to the extent of the period of work without pay, then

that record is turned over to the chief guard, who then sees to it that the man works that period of time without pay, which then clears his record. The chief guard has no other jurisdiction except to carry out the decision made by either the manager or assistant manager.

The WITNESS. Isn't it a fact these clothes are issued under an emergency in a hospital and not transferable from one institution to another?

Major FROEMMING. Clothing accounts follow a man throughout his various admissions in the various facilities, and if a man comes to us and he is in need of clothing before we can get his record, we have an emergency supply of clothing that is immediately utilized to protect him against the elements. No man is allowed to or permitted to walk on the streets here with the soles of his shoes out or in threadbare clothing. Sanitation among our men is one of our first objectives when a man gets here, and clothing, of course, is the important factor in that particular procedure.

The WITNESS. Would you tell them that didn't exist in the years of 1931, '32, and along in there, in the Economy Act? [Applause.]

Congressman DOMENGEAUX. Just a moment. We are going to conduct this hearing properly, and we can't do it with these expressions of approval or disapproval, this clapping, and things of that kind. I wish this clapping would discontinue in the future, because we have got to do this thing in an orderly manner. We are not over here to have a witch hunt, nor are we here to whitewash anyone. We want these facts in an orderly manner, and these interruptions will interrupt such a procedure.

Will you please continue?

The WITNESS. Isn't it a fact it wasn't enacted, and then they did issue overalls and second-hand clothing that was laundered to be issued to fellows in this institution until after they had did their dump, or their work, to get their clothing, but up until 1934 there was nothing like that existed in this institution?

Major FROEMMING. To my knowledge—and I have been affiliated with this station for over 20 years off and on—we have never permitted any of our men or expected them to walk around the company streets here in threadbare clothing, clothing that was not serviceable. It is true that men when they first come in, in connection with their original admission, are issued brand-new clothing that has never been worn before, but we do reclaim clothing that still has wear in it, and men after they have been issued the original new outfit are then expected to use some of this used and reconditioned clothing.

Congressman DOMENGEAUX. Thank you, sir.

By Congressman DOMENGEAUX:

Q. Have you anything else to contribute, sir? Thank you very much for coming up.—A. I wish they would clear up this dental condition and I could wear a glass eye, but I have never been able to obtain them. As I say, they want me to go to domiciliary in order to do that. Now, I don't think I belong in that domiciliary.

Q. Those are the regulations out of Washington.

Congressman DOMENGEAUX. Major, may I ask this question: The regulations that are in existence at Wood, as well as other hospitals, originate out of the central office in Washington; is that correct?

Major FROEMMING. That is correct.

Mrs. CLARA DOEHLER, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you give your name, please?—A. Mrs. Clara Doehler.

Q. What is your occupation?—A. I am employed as a nurse.

Q. You are an employee of Wood Hospital as a nurse?—A. Yes. I am representing the nurses of Wood, Wis.

Q. All of the nurses?—A. Yes.

Q. I see.—A. There is an article in the August issue of Readers Scope magazine slandering the nurses, and Miss Metcalfe and Miss Petty. The nurses objected to this article and selected a committee of three.

Q. How many nurses have you at Wood?—A. I can't tell you.

Q. Approximately.—A. There must be about 175.

Q. What percentage were present there?—A. Everyone that was on duty at the time. This nursing body selected a committee of which Miss Kindt, Mrs. Stampfel, and I were members, and we are all present at this meeting. All they asked us to do was to draw up the petition protesting this article in the magazine.

Q. Do you know the author of that article?—A. It was under the heading of Mr. May.

Q. John L. May?—A. John L. May. The nurses had this meeting and had the protest gotten up and circulated, and we had practically 100 percent of the signatures of the nurses objecting to it, which we would like to turn in.

Q. Yes. Will you read the caption of this petition?—A. (Reads:)

We, the nurses of Wood, Wis., do protest the article appearing in the August issue of Readers Scope as malicious and unwarranted, and with no foundation whatsoever.

We wish to vindicate Miss Metcalfe and Miss Petty publicly of any accusations made against them. Never at any time have either Miss Metcalfe or Miss Petty intimated us or given us wrong or secretive advice. Never has she suggested that cleaning be paramount to the veterans care, and to our knowledge at all times has the veterans well-being been foremost in her mind.

We would welcome an honest investigation by any committee or any organization at any time and are willing to appear before said committee.

Many of the nurses have sons, brothers, or husbands in this war, who have only one desire—to give the best of service.

Regardless of the articles we read, or the comments we hear, we will still continue to give the veteran the same treatment, knowing deep in our hearts no one has a just complaint. And any person who is really concerned of their welfare or morale is willing to help the institution build up, and not tear down, the things the boys have fought for.

I have the signature of about 150 girls. There are some on leave.

Q. Do you mean by "girls" nurses, employees?—A. These are all nurses employed here. There was no coercion on anyone's part. The signature was given willfully by everyone that has signed.

Q. Did anyone refuse to sign?—A. There were two. One didn't read the article at all; just asked—made reference to us, and we contacted. I want to say the nurses on this committee—one is a World War I nurse, another is the wife of a World War I veteran. I am the wife of a World War I veteran who has died. I have two sons in the service. One son has a Purple Heart—has received a severe wound. We are here to give to these boys what we would give to our own.



Q. How long have you been connected with the institution?—A. About a year and a half.

Q. Where were you before then?—A. I have been a nurse for many years, and I have done nursing at Milwaukee Hospital in town. During the war, when the need was great out here, I thought with my sons in service I should come out and care for where the need was great.

Q. Yes. Have you ever seen any evidence of mistreatment or brutality?—A. I can truthfully say I did not.

Q. By the doctors, nurses, or attendants to these patients?—A. I can truthfully say that I have not.

Q. What is your estimation of the type and the kind of food that is usually served at Wood to the patients?—A. I think the food is really excellent compared to the times we have. If they were out on the outside they would find it is very difficult to get things at the present time. Sometimes food probably was cold, but with the new system they have I believe the trays come in to the patients hot.

Q. You read these charges with particular reference to Miss Metcalfe?—A. We couldn't answer every specific charge in the magazine, because there are specific things we didn't know. They make mention of the nurses dumping a person on his face, and different references in here. I never seen anything like that, and the nurses wholeheartedly object to any statements with reference to that.

Q. Would you say there exists at Wood a feeling among the employees and the patients that if they would disagree or disapprove with Miss Metcalfe or other officials that they would be in danger of being sent to the mental ward in retribution?—A. I have never seen anything to that effect.

Q. Do you feel that such a feeling exists among the patients? Has anyone ever spoken to you about that?—A. Not as far as that, referring to the mental ward.

Q. Thank you very much. Have you anything else to offer?—A. Will that be put into the record?

Q. Oh, yes; this will be put in the record. This is a petition including all the nurses, excepting two.—A. And except the nurses that are on vacation and I couldn't contact.

Mr. JOHN L. MAY. May I speak to the members and the public?

Congressman DOMENGEAUX. I am conducting the hearing, sir.

Mr. MAY. I asked to speak to the members here, and the public.

Congressman DOMENGEAUX. Sir, this is not a meeting for your glorification.

Mr. MAY. I am not looking for glorification, my friend.

Congressman DOMENGEAUX. This is a meeting conducted by proper authority, and I ask you to come up and testify on the stage.

Mr. MAY. I am not testifying until I am subpoenaed. I will speak here. I am not going to take the stand until I am subpoenaed, my friends. Can I talk, or can't I?

Congressman DOMENGEAUX. I am sorry, sir. This has got to be conducted properly. I am very happy to have you, and I invited you to be present.

Mr. MAY. I ask privilege for the press to meet with me immediately after this meeting.

Congressman DOMENGEAUX. I may say to the audience that the committee is very happy and anxious to hear from Mr. May as a witness.

Mr. MAY. When I am subpoenaed I will appear.

Congressman DOMENGEAUX. Mr. May came to see me at my hotel 2 nights ago with a reporter of the Milwaukee Sentinel, at which time I invited Mr. May to be present personally. Now, if he insists upon the technicality of a subpoena I will be very glad to give him that subpoena, but Mr. May must realize that the committee is conducting this investigation for only one purpose, and that is to secure the facts. It has got to be done in an orderly manner, and if Mr. May cares to testify as a witness he is welcome to do so at this time.

I say this: That if Mr. May refuses to testify to some of these serious charges that he has made, he has created an unspeakable harm and wrong, because these articles have been circulated throughout the magazines of this country—throughout this magazine, certainly throughout this country, creating the impression that these hospitals are butcher shops, and if he cannot substantiate the charges he has made, he has done an unspeakable wrong, because it has brought anxiety in the minds of families of these veterans who must come to these hospitals.

Mr. May is now given the opportunity to substantiate these charges where he will not be hampered, but he must come as a witness and not for the purpose of making a public speech.

Mr. MAY. I reiterate the statement that I made, that I will appear as a witness when I am subpoenaed.

Congressman DOMENGEAUX. All right, sir, I will give you a subpoena if you want that. I don't know whether you want to testify at this hearing, Mr. May. I am not so sure that you do.

Mr. MAY. I will be only too glad to.

Congressman DOMENGEAUX. Does anybody else care to testify?

JOHN J. HOUGH, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you give your complete name, sir?—A. John J. Hough.

Q. Where are you from, sir?—A. Chicago, Ill.

Q. We are very happy to have you with us and will be glad to hear what you have got to say.—A. I gripe about this waiting for a pension. I have been in here 9 months and I haven't got no pension as yet.

Q. You are a veteran of this war?—A. I have 23 years' service, retired out of the Marine Corps, and I have to waiver my retire pay in order to get this pension.

Q. There is no doubt—A. What I am griping about is waiting so long.

Q. I say you are perfectly correct. We all recognize that sufficient planning had not been done to anticipate the very heavy load that would result in the adjudication of claims of the veterans who are returning from this war. I believe that the organization is correcting itself, and it is going to be operated much more efficiently. What you say there is perfectly correct.—A. Here is the thing there—

Q. There was a congestion of claims where these veterans were not adjudicated, and it should not have been done, but I think they are

trying to perfect the machinery so that these claims can be taken up properly.—A. I come into his hospital on October 25. Here is a letter from Washington: "This office has received no official notice of your admission to the Veterans' Administration." That is 5 months later. There is something wrong here at the office. That is from the Marine Corps. I wrote to them to find out what the score is. They received no notice. That is marked the 9th of March, and I come in here the 25th of October, and they haven't been notified I was in this hospital.

Congressman DOMENGEAUX. Would you have an explanation for this, either of you gentlemen? This is a letter dated March 9, 1945, on the letterhead of the headquarters of the United States Marine Corps at Washington, to this gentleman.

Major FROEMMING. We do not report the admissions of a veteran to any particular branch of the service. We do, immediately upon his admission here, report to our Statistical Division in Washington, that is, the office of the Veterans' Administration.

A. How are they going to find out that I am here?

Congressman DOMENGEAUX. What would be the process? Does the central office notify the service?

Major FROEMMING. The central office at Washington knows at all times where veterans are hospitalized or domiciled. Any change in status is immediately reported to that office.

Congressman DOMENGEAUX. Is there any responsibility, or would there be any good purpose served in notifying the former company or that branch of the service where the veteran was formerly before coming to the service of the fact that he is in a veterans' hospital?

Major FROEMMING. Inasmuch as we deal with men after they have been discharged from active service, there appears to be no good reason why the former branch of the service in which they served should be notified when they are hospitalized. That question has never been presented.

The WITNESS. Why were my claims sent from here to Hines, instead of Washington?

Major FROEMMING. I couldn't say, unless we examined your claim.

The WITNESS. All retired claims are supposed to go to Washington; at least they should go there.

Congressman DOMENGEAUX. I think the explanation of that is—and it should not have occurred, but we have got to admit these things—that a great number of claims came at one time from the veterans of this present war, and it takes a certain time in which to adjudicate and settle these claims, and the personnel and the organization was not able to do it. Isn't that the reasonable explanation?

Major FROEMMING. It may be true to a certain extent, although I prefer to take this gentleman's name and have our division look up his case and we could then have a very definite and specific answer.

Congressman DOMENGEAUX. I wish that would be done.

By Congressman DOMENGEAUX:

Q. Is that satisfactory?—A. I want to know about this idea of a guy getting \$20 while he is in a hospital.

Q. That is a law.—A. Why should a married man get it?

Q. Many years ago, to discourage a practice that was then prevailing in the hospitals, Congress passed a law that a veteran with



service-connected disability, if he went to a hospital and was single, his compensation would be reduced to \$20 a month. Now, whether that was logical or not is debatable. The fact remains that that is the law.

I may tell you that this committee, of which I am a member, has been seriously considering in the last few months the possibility, and there is legislation pending which is under consideration to do away with the differential and put the single man in the same classification to receive compensation as a married man, and if he goes into the hospital his compensation would not be reduced. The reason why that is being done is because we feel that many veterans, particularly those who are tubercular patients, are leaving the hospitals against medical advice, a. w. o. l. without being cured, because this \$20 a month is not adequate, is not sufficient. Congress is now seriously considering the elimination of that condition.—A. Take a guy that has TB and is in here 2 years, when he is out of here he is broke.

Q. That is the law today, and until it is changed—A. Is that what you people are trying to do, straighten these things out?

Q. Yes; that is right. Congress makes plenty of mistakes.—A. You can't write to a Congressman and get an answer back.

Q. Oh, yes; you can. I answer my mail. I think all Congressmen answer their mail. They have got to come up for reelection every 2 years.—A. About this recreation, why can't these patients here, for instance, get a bus or something and go over to see a ball game?

Q. I don't know why they can't.—A. They are not allowed 50 feet away from the building. A TB patient can't go over there because they are mixing in too much with the patients. They come in here and sit, and we are out in the open at a ball game.

Q. You feel that transportation should be furnished?—A. Or let them walk over there. They are not allowed over there. They are not allowed 50 feet away from the building.

CONGRESSMAN DOMENGEAUX. I don't know. Would you care to comment on that?

Lieutenant Colonel MULLINS. The patients in the general hospital are in bathrobes and pajamas at all times. Those in the general hospital and also in the tuberculosis unit are in bathrobes and pajamas, and in order to keep a lot of the men who walk up and down the streets from wandering indiscriminately over all these large grounds, we have asked that the patients remain close by the building. Our tuberculosis unit here, which consists of 432 beds, is a rather large unit. We are making efforts to improve our recreational facilities here. We are also making every effort that we possibly can under our present limited means to keep the general patients and the tubercular patients more or less separated. It isn't that we are trying to ostracize or penalize the men over in the TB section, but it is common sense and good medical judgment to prevent intermingling that way.

Our baseball games over there are for patients or for the members who are in clothes. I believe you people can readily understand that if we permitted all of our patients to go over in bathrobes and pajamas, and such as that, it wouldn't be but a short time until we would be faced with a more or less impossible situation here.

Another thing: Our patients over here, regardless of their being able to go to the dining room for meals, and such as that, there are a great number of them who are physically unable to go over to a

ball game and sit there in the sun through the excitement of an hour and a half's or 2 hours' game.

Congressman DOMENGEAUX. Thank you, sir. That sounds very logical.

The WITNESS. Wouldn't that be up to the doctor to stop them from going, or do they have to get permission to leave the ward and go to a ball game?

Congressman DOMENGEAUX. You heard the doctor's explanation. They are running this hospital, and they have got to have regulations.

The WITNESS. I admit that, certainly. If it weren't for the Milwaukee Elks and Eagles, we wouldn't have no recreation here whatsoever.

Congressman DOMENGEAUX. At this time what are the recreational facilities that are provided for the patients generally at the hospital?

Lieutenant Colonel MULLINS. The recreational facilities in our hospital consist of our picture shows.

Congressman DOMENGEAUX. How many times a week, sir?

Lieutenant Colonel MULLINS. Tuesday afternoons and Friday afternoons. Later on there will be four shows a week in this theater. Two of them will be for general patients and two for the men over in the tuberculosis unit. As you men know, we have a great number of stage attractions—musicals, and such as that.

Congressman DOMENGEAUX. What is done in the direction of vocational work for those patients, particularly the tuberculosis patients who are bedridden for an indefinite period of time?

Lieutenant Colonel MULLINS. At the present time there is available not as full coverage for that type of work as we wish. That is being corrected. Our occupational therapy, their aides visit the wards of these men who wish to do any occupational therapy, men who are unable to appear down at the shop.

By Congressman DOMENGEAUX:

Q. Any other thought?—A. No.

Congressman DOMENGEAUX. I wish to say at this time, also that no one has been subpoenaed, and these witnesses are coming up voluntarily.

CEPHUS A. ROSS, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, please, age, and address?—A. Cephus A. Ross.

Q. How old are you, please?—A. Twenty-one.

Q. Your address?—A. Chicago.

Q. Chicago, Ill.?—A. Yes. I have a list of complaints here I would like to read from ward 28, tuberculosis.

Q. Are you a TB patient?—A. Yes. [Reading:]

VETERANS' ADMINISTRATION.

WARD 18, TUBERCULOSIS,

Wood, Wis., July 20, 1945.

Mr. REPRESENTATIVE: The following patients believe these complaints will make their recovery a speedy and comfortable one:

Separation of negative and positive patients—

Q. Let's get on that. That is active and non-active tuberculosis?—

A. Yes, sir.

Q. They are not separated at the present time?—A. No, sir; they are not. [Reading:]

Patients should know more about their cases.

I have been here going on 2 months and I don't know anything.

A larger recreation room.

We haven't got one and we are crowded into a small room. This list is signed by the members of ward 18, and it is about 33.

Q. Those are the three complaints?—A. Yes.

Congressman DOMENGEAUX. Well, I certainly have found these same complaints in other tuberculosis hospitals, and I don't know about this.

Is there any reason, except for the question of space, why the negative and positive patients are not separated? It seems very desirable from a medical standpoint, doesn't it, Doctor?

Lieutenant Colonel MULLINS. That is right. That is the only reason, sir, the limited space on that ward. The complaint just made by the young patient is a justifiable one. Owing to the crowded conditions, it has not been possible to keep separated the man with negative sputum from the man who has a positive sputum. That is a situation that we will admit does exist in some cases, but I assure you when it is possible it will certainly be corrected.

Congressman DOMENGEAUX. Because it is necessary from the standpoint of good medical practice to separate these cases?

Lieutenant Colonel MULLINS. It is desirable, yes, sir.

Congressman DOMENGEAUX. Now, Doctor, about this complaint that patients should know more about their cases. We recognize that tuberculosis requires a long period of treatment, and that the building up of good morale contributes to a speedy recovery. Is that correct, sir?

Lieutenant Colonel MULLINS. Yes, sir.

Congressman DOMENGEAUX. A tuberculous patient is irritable because of his long period and is anxious to know his condition. Have you any thought on whether the patients here are properly informed as to their condition, or should that be done from a medical standpoint? I don't know.

Lieutenant Colonel MULLINS. Well, speaking as one who has had several years' experience in tuberculosis hospitals—and I assure you that was the happiest time of my entire career in this service—I found the patients very cooperative and easy to get along with. It was my policy to always contact my patients as soon as I was able to make a determination, and if they wished to see their X-rays I would show them and I would go into detail and explain, or at least attempt to explain to these patients just what they had and what we expected. I think it is highly desirable in the great number of cases that you do that, because I honestly believe by following that procedure you will secure greater cooperation from your patient.

Congressman DOMENGEAUX. Thank you, sir.

By Congressman DOMENGEAUX:

Q. Have you anything further?

I want to congratulate you for coming up here. I think these suggestions are constructive, and they are made for the purpose of constructive criticism in benefiting general conditions, and your attitude



about this is very fine and I want to congratulate you.—A. Would you like to keep this?

Q. Yes, I would like to make this part of the record.

(Witness excused.)

ATTLESS LOMAX, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you give us your name, please?—A. Attless Lomax. I came up here to ask some questions. I ain't got nothing to tell. I was transferred from Hines up here in September, and I was sent to ward 18. I missed my check for 3 months. I asked the ward doctor for a pass to Chicago. He give me 2-day pass.

Q. Are you an active tuberculosis?—A. Active, heart trouble and arthritis.

He give me a pass to Chicago and I went there, and the second night I had taken a hemorrhage. I lay in bed 2 days, and the health department found me. They sent me to the county hospital. I overstayed my pass. Well, they called the TB department, Soldier's Service, and they sent an ambulance, put me on a train, and sent me up here. Dr. Wolff kept me 16 days, gave me an a. m. a. I had a doctor's report, my condition when I got here, what condition I come up there. Wolff gave me a discharge out of the hospital without even a half-way ticket in January, not even a meal.

Q. Do you mean to tell me—A. The records will show it. You can look at my record.

Q. Let me get these facts straight. You requested a pass to go to Chicago to see about your check, which was overdue?—A. That is right.

Q. And while you were over there you developed a hemorrhage?—A. That is right.

Q. And was placed in a hospital?—A. In the county hospital.

Q. In the county hospital?—A. By the health department.

Q. By the health department?—A. That is right.

Q. And it was how many days afterward before you could return to the hospital?—A. It was about 8 days.

Q. And when you got back over here Dr. Wolff gave you—A. He kept me 16 days; picked the coldest day of January to turn me out on the street without a dime.

Q. You mean you were put out of this hospital?—A. I was put out; yes, and—

Q. An active tuberculosis?—A. That is right.

Q. What is the name of this doctor?—A. Dr. Wolff. I went to the head doctor. He said, "Go to see Dr. Wolff." If you are colored and you come in there, you get ward 18. If Dr. Wolff say you can stay, you stay; if he say you go, you go.

Q. What I want to know about this very serious charge—A. That is the truth. Look at my record and you will see. The report the doctor sent is on my record.

Q. This a. m. a., what is that?—A. Against the doctor's advice. He give me that for being a. w. o. l.

Q. He gave you this a. m. a.?—A. That is right.

Q. That is leaving this hospital against medical advice?—A. Yes, sir.

Q. You were not leaving here against medical advice; you were leaving here because you were kicked out?—A. I overstayed my pass, you see, and he held that against me and he is still holding it against me, and it is 9 months. All the way I could come in there is that-a-way.

Q. You are an active tuberculosis case?—A. That is right.

Congressman DOMENGEAUX. Doctor, this is a very serious charge. I want a complete report on this.

VOICE FROM THE AUDIENCE. That is right, too.

Congressman DOMENGEAUX. I am not asking anybody else up here. I don't want the audience expressing their opinion one way or the other about this, or any other case. If they want to testify let them come up here and testify.

The WITNESS. There is not a doctor in the hospital that is over Dr. Wolff. He has charge of the colored patients. If you are half dead or well you get ward 18, and Dr. Wolff's word goes.

Congressman DOMENGEAUX. If what this veteran says is true—

The WITNESS. It is true; look at my record.

Congressman DOMENGEAUX. That he was put out of this hospital in midwinter with active tuberculosis, under those circumstances; I want a very complete report on that.

Q. Anything else?—A. No, sir; that is all.

Q. That is enough.—A. If you don't do something about it, I am going to Judge Barnes in Chicago.

Q. Don't you worry about that, Uncle.

(Witness excused.)

DOROTHY DESPINS, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, please?—A. Dorothy Despins, D-e-s-p-i-n-s, wife of First World War husband and five brothers, three brothers back in this war; four nephews. The brother—the oldest brother, the First World War, couldn't find a job, couldn't get his pension through until it was too late. He had a nervous break-down.

Q. Your brother?—A. My brother, William F. Reed. He had a nervous break-down and attempted suicide. He was taken to the Emergency Hospital. From there he was transferred out here.

Q. When was that, ma'am?—A. That is about 14 years ago.

Q. I think you can see that I want to get down to the bottom of these things. Do you know these things of your own personal knowledge?—A. Of my own personal knowledge is correct.

Q. I want facts that you have seen.—A. Facts that I can back up.

Q. As a witness.—A. Yes.

Q. I mean I want things that you have seen and that you can testify.—A. That is right.

Q. That is fundamentally a rule of law.—A. So when he left the hospital—they gave him wonderful care at the Emergency—they transferred him out here. He was put in the ward with the very worst mental-condition fellows.

Q. Do you say he had attempted suicide?—A. Yes, he had; not insane, because they released him later on on a visit from Wood, Wis., also from here.

Q. Your criticism is that he was placed—A. Where he should never be placed.

Q. In this mental ward?—A. That is the reason he is one, as General Butler said, of the living dead now at Downey, Ill., put in a condition that he is not able to be on the outside any more from the mistreatment that he got.

Q. He is now at Downey, Ill.?—A. Yes.

Q. In the hospital there?—A. In the hospital there at Downey, Ill.

Q. That is a mental hospital?—A. Well, yes, but still he is permitted to come home on vacation trips, but yet he is denied the privilege of the ground and is kept in a locked ward.

Q. That is at the hospital over there?—A. Yes. Another thing I want to bring out is that later on he got his bonus, which he had, every bit of it. Part of it is still at the hospital. He was not permitted to buy his own clothes. They forced him to wear what they issued at the hospital. When they brought him home on a visit the elbows of his underwear, the shirt, and top coat was out, the naked elbow sticking through, and he was released from the hospital in that condition without no dime of his own money to spend while he was on the vacation. I can back that up by Mr. Glassner. You know who Mr. Glassner is?

Q. He is at Downey?—A. Mr. Glassner right here. He called Dr. Goode and released some of his money to get a suit.

Q. Where is his money now?—A. His money is still down here. My sister, taking him into Brill's in this condition, naked elbow, charged the suit of clothes; in fact, dressed him out on her credit, while he had money down there he couldn't even get.

Q. Who was the tutor or curator?—A. My sister was his guardian until he was released as capable of being on the outside. The only thing that put him back was the Gallun Tannery strike, and somebody threw a bottle through the window and it upset him again, so he went back.

Q. You spoke of brutal treatment that put him in the hospital. What brutal treatment are you speaking about?—A. When he went into that mental ward.

Q. Where?—A. Right here.

Q. Fourteen years ago?—A. Yes.

Q. And what?—A. They would come and take him, if he did a little something that wasn't right—they were not responsible; they didn't know what they were doing. I have seen them take a colored man by the shoulders and boot him back all the way to where you put them in a room by himself.

Q. You don't know the name of the attendant?—A. No; I don't.

Q. That is 14 years ago?—A. Fourteen years ago. I had to go over their heads to have my husband's teeth extracted out there. A Dr. Hughes went to the front for me, and he was head physician at the time.

Q. Where is your husband?—A. He is working now at Allis-Chalmers, put back into good health through my fighting for him. He came out here in very, very bad condition, practically dying on his feet.

Q. You want to give the doctor some little credit for putting him back on his feet?—A. Oh, yes; u-huh, you bet. Good doctors here,



you bet. There is good doctors here and good nurses. There is some bad doctors, too. There are some doctors that don't live up to what they are supposed to live up to.

Q. You find that in civilian?—A. I mentioned the doctor, his name is Dr. Stein. He refused to go to the front and put it on record that my husband was supposed to have his teeth extracted until he walked away on him. He wasn't getting the treatment he was supposed to get. He asked me could he come home. I said, "I will ask the doctor." He says, "If he goes out of here it is against medical advice, and he cannot come back for 90 days." Well, he was in such agony that he walked away on them. We walked the floor all night with him, and I called him, Dr. Hughes, the next morning, and he says, "You bring your husband back out here and bring him directly to my office." Dr. Hughes walked all the way back with us to my husband's ward and called Dr. Stein on it. He says, "This man needs care. See that he gets his treatments." And also called the head nurse—I don't remember her name. Well, then, I asked the doctor then and there, "How about these bad teeth." He says, "Positively, it is detrimental to the health." He said, "Have you got bad teeth?" He said, "Yes."

He said, "Doctor, make a note that these teeth are to be extracted as soon as the man is able." They come out, and nothing was done.

Q. Are you sure of all these things?—A. Positively. I can back it up by Dr. Hughes, and also Dr. Stein, if he is here. And then I went over his head and I went to Dr. Hughes again. Dr. Hughes sent me to somebody under him. I don't remember his name, although I have it at home. So, when I went in to see him he sticks his feet upon the desk in front of my face, scratches his head, and he says, "Sometimes," he says, "it is just painful to tell these veterans that they can't have this or that done."

I said, "You mean to say he can't have his teeth extracted here?" He says, "That is just it." So instead of bothering Dr. Hughes again, I went home and wrote him a letter. He called me back out at the office, and Dr. Hughes saw that my husband's teeth were extracted, but I had to go over some of the big shots' heads to do it.

And I also wrote a letter to our late President Roosevelt the conditions I found out here in the dining room when I worked here last August and September.

Q. What did you find?—A. I find the boys having to pick flies out of their food. Anyone that is out there that knows it can speak up.

Q. I have been through these hospitals for 4 days and I haven't seen two flies.—A. They cleaned it up. You are not doubting me, are you?

Q. Oh, no.—A. Well, don't. I will bring the head waitress in here and the rest I worked with. I had taken time out on my tables, and I took the paper napkins and folded them over their milk bottles and milk pitchers and salads. There was the great, big garbage wagon setting in the dining room. A person sick wants to look at a garbage wagon being emptied in front of their eyes! Do you call that a thing for a hospital? I don't.

Q. I don't. May I make this observation?—A. Yes.

Q. I want to be fair, as I know you do. I have never seen a more spotless, a cleaner, a more sanitary looking institution.—A. That is right.

Q. Where food is served as I have seen at Wood Hospital. Now, that is the condition today and I don't believe that that can be con-

tradicted. If that was a year and a half ago, that is different.—  
A. No; this was last September, not a year yet. They did make a change, because one of the ladies in the Boston Store told me there had been a big change.

Q. Have you been here lately?—A. I was speaking when I was here working here, and what I could see with my own eyes.

Q. Continue, then.—A. One of the boys asked if he could have a second helping of dessert, which was a piece of pie that he wanted. After all, if their clothing are taken away from them and they can't get on the outside, they can't get friends to get little extra pieces of pie or extra dessert. This little flunky said, "You know good and well there is no seconds on desserts." I said, "Maybe that is what you think." I go out and load up a tray of ice cream and pie and ask who all wanted another cut of pie. That is what they got left, one meal, you might say, for what they fought for. If they can't have that, they have got nothing left.

Q. They have to be well fed, I agree with you.—A. The food looked good when it come out, but what the hell would take place before it reached the boys' tables? It really wasn't fit to eat.

Q. Well, madam—A. What I could see with my own eyes.

Q. I don't believe there is a man in the audience who can say the food wasn't good and clean, healthy and wholesome.—A. I am speaking of a year ago.

Q. That is all right. Continue. You have a right to testify.—A. I wrote a letter to our late President and asked him to please look into it to see that they got better care.

Q. He was running the war. He was pretty busy at that time.—A. Not too busy to answer me.

Q. Thank you, ma'am. Have you anything else to contribute?—A. I hope they get the care that they are entitled to. Anything that I have said here I can back up by letters at home, and by Mr. Glassner. He is still here, isn't he?

Q. I don't know. I have never heard the name before.—A. State's attorney general. He wrote me out a slip of paper to go over. He said, "You could call right from my desk, only this phone is for the grounds only. Go over to the post office and call Dr. Goode long distance and tell him that he should know if the veteran himself had no money there; there is a fund there, and no veteran should come out on a vacation without at least \$10 for spending money while he was there." He couldn't even get his own. Have I got a kick coming, or have I? [Applause.]

Q. Thank you, ma'am, for your contribution.

Congressman DOMENGEAUX. Fellows, I have no particular hesitation about this approval or disapproval, but I have requested that that be discontinued, and I do wish you would do that.

(Witness excused.)

(A new witness appeared before Congressman Domengeaux to testify, but did not supply her name.)

Congressman DOMENGEAUX. Do you wish to testify, ma'am?

The WITNESS. I am the sister of this brother you were just speaking of.

Congressman DOMENGEAUX. If it is the same testimony—

The WITNESS. No; it is not. It is the treatment down in Downey.

CONGRESSMAN DOMENGEAUX. I am not investigating Downey at this time. I may later, there. I want to find out about Wood at this time. Later on—

THE WITNESS. I want to take up a claim since my World War veteran died that I lived on \$26 a month.

(Witness excused.)

SIGFRID MANOWSKI, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, sir?—A. Sigfrid Manowski.

Q. How old are you, please, sir?—A. Twenty.

Q. Where are you from?—A. Hammond, Ind. I had a bronchoscope operation and since that sometimes I lose my voice. Last year I needed an operation, extrapleuralpneumoniosis, and made it 4 months to get to Hines. I made it 1 month to get an operation. After that I returned to this place and I—2d March. They reached the decision I was to get thoracoplasty. They said they had no instruments at this time, but they were sending for them. Now it is 4 months later. Operation was supposed to be performed at this month. I have four papers since, one of them at the present time at my mother's house. Still they haven't got the instruments. I asked them for an X-ray. After a couple of complaints I finally got it. He said they can't take so many X-rays. I was supposed to be dying and I was promised an X-ray 1 month after I got up again, and no X-ray was taken. Three months after that I argued for this, and one was taken.

Our own consulting surgeon, Dr. Steele, looked the X-ray over and said thoracoplasty should be performed immediately.

Q. How long ago was that?—A. Four weeks.

Q. It hasn't been done yet?—A. It hasn't been done today. I asked my ward doctor when I sent the fourth paper to my mother to sign—

Q. To get her permission for this operation?—A. She gave her permission before, and I signed three other papers previously. Still my ward physicians says they haven't got the instruments.

Q. Who told you they didn't have the instruments?—A. Dr. Meyst and Dr. Guilbert.

Q. Are they in this ward?—A. Dr. Guilbert is the chief medical officer.

Q. Is that at Hines?—A. That is right here. They said they were sending for them. Why does it take 4 months since this hospital has the same priority as the Army to get those instruments?

Q. Is that a new type of instrument?—A. I don't think so. It used to be at least 400 TB patients in this institution, which is more than the average of a TB sanatorium. Right now everybody is signed up for phrenic nerve, thoracoplasty, or some other operation.

Q. Where do they do it?—A. They do it right here since Dr. Guilbert came in. Before we had none of those things done. Since he came we had those operations done. Still I am not the only patient waiting for thoracoplasty. A thoracoplasty is very important. When you come in in a wretched condition, and you need a thoracoplasty—I only have one lung uninjured, and I haven't very much on my other side, but you can give me enough troubles as it was before to put me



down and out for good. The lung operation is delayed, and danger for me to happen. It might be cheaper for the hospital to send me out in a box than buy those instruments. I am not the only patient making this complaint.

Congressman DOMENGEAUX. Can an explanation of this general statement be made, Doctor?

Lieutenant Colonel MULLINS. It was in April, or the 1st of May, that we were able to secure the services of a competent chest surgeon at this place.

Congressman DOMENGEAUX. How long has this been a tuberculosis hospital?

Lieutenant Colonel MULLINS. Oh, a number of years. Just how long, I wouldn't know, sir.

Congressman DOMENGEAUX. How long have you been without the use of a competent chest surgeon prior to that time?

Lieutenant Colonel MULLINS. That was up until April or May this year, for the simple reason our central office had us transfer our pulmonary tuberculosis surgical cases to the different centers. Hines was the place that we had to transfer from here. The tuberculosis unit down at Hines, of course, rapidly filled and we were unable to get our transfers effected. Consequently, when we had an opportunity to secure the services of this chest surgeon, we immediately got him, received permission from our central office to do this type surgery here, which we have never been allowed to do before.

Congressman DOMENGEAUX. Why not, sir; is it so technical?

Lieutenant Colonel MULLINS. Yes; and they have had the different centers for this type surgery; consequently, we didn't have any instruments here. We go into the different manufacturers for these; we go into Washington; we get Army and Navy priority on these instruments, but it takes them a certain time to make them up. I have even tried borrowing instruments from other veterans' hospitals. I have tried to buy instruments, I have tried to rent instruments; but I believe that the majority of those instruments are here at the present time, and Dr. Steele next week is going to start on his thoracoplasties. That is the reason for the delay.

Congressman DOMENGEAUX. You have some 400 beds?

Lieutenant Colonel MULLINS. Four hundred and thirty-three beds.

Congressman DOMENGEAUX. You have had about that number for many years?

Lieutenant Colonel MULLINS. I think we have had an average of about 400—350 tuberculosis beds here at Wood all the time.

Congressman DOMENGEAUX. And the practice that has prevailed throughout these years is that tuberculosis patients requiring chest surgery are sent to other centers to get that?

Lieutenant Colonel MULLINS. That is right, sir. That was our central-office decision.

Congressman DOMENGEAUX. Should not a hospital of this size, having that many tuberculosis patients, be complete in every respect as to treatment and surgery for the maximum benefit of the patient?

Lieutenant Colonel MULLINS. Yes; and the great majority of us out in the field in these hospitals have always thought so, but we were unable to sell the central office this idea.

Congressman DOMENGEAUX. All of these instructions come out of the central office from Dr. Griffith, the head of the medical department?

Lieutenant Colonel MULLINS. That is right, sir.

The WITNESS. A. Why do you keep a doctor that refuses you tests and argues men's trouble with the front office, and you want to determine whether that patient is positive or negative. Yet we don't get any sputum tests. I haven't had one for 4 months.

Lieutenant Colonel MULLINS. I don't know a thing about it, but I will investigate and see.

The WITNESS. The doctor comes in in the morning, "Good morning, gentlemen," and that is all.

By Congressman DOMENGEAUX:

Q. You say you have not had a sputum test for 4 months?—A. Fellows in the tuberculosis side that haven't had a sputum test for more than 4 months.

Congressman DOMENGEAUX. What is the recognized technique, requirements on that, doctor? How often should sputum tests be had?

Lieutenant Colonel MULLINS. Is Dr. Guilbert in the house?

Congressman DOMENGEAUX. He is on vacation.

Lieutenant Colonel MULLINS. The patients, when they are admitted to the hospital, sir, have routine sputum examinations as well as X-rays of the chest, and all special examinations necessary. There is always a series of sputums run on these cases to demonstrate the positive presence of tubercle bacilli. A certain number are run as certified specimens, and if they continue negative and yet your X-ray and physical findings indicate the definite presence of a pulmonary lesion, gastric lavage or guinea-pig inoculations or both are always done in those cases. Now, it is sanitary procedure, I believe, to have routine specimens brought on patients even though the diagnosis has been definitely established. The complaint of the young man there I know nothing of. It is the first I heard of it, but we will certainly look into it.

Congressman DOMENGEAUX. Would it be proper, with one with active tuberculosis on his condition to have the sputum tests delayed over such a period? Is it more desirable to have them more frequently? I don't know.

Lieutenant Colonel MULLINS. He spoke of having a cavity. In all probably all of his sputums have been positive, but I don't know. He may wait until the surgery would close the cavity. I wouldn't know.

The WITNESS. My sputums have been negative. When I signed for operation I had to tell him what kind of operation I am getting and what side I am getting it. It is very difficult for a doctor not to know, and sign for something and not do it. I have asked Dr. Guilbert and Dr. Meyst. I want this operation done. I want it bad. It is the only thing that is going to help me, and I want to get it over with as soon as possible. I want this operation, extrapleural. I stayed in bed and took my care. I am nervous. Nobody tells me anything. I wish you would look into this. I want an operation very bad. It is the only thing that will help me.

(Witness excused.)

Congressman DOMENGEAUX. Will you kindly look into this case?

Lieutenant Colonel MULLINS. I certainly will, sir.

STANLEY BACHORA, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, sir?—A. My name is Stanley Bachora. I am from ward 20. I am one of the TB patients myself. I have been here a little over 3 years now, got in here in July 1943. Ever since, I haven't been down and out; I have been always up on my feet and felt pretty good. Never had any fever, break-downs, or hemorrhages of any kind. Still I am here. Now, here I didn't have an X-ray for a year; sputum more than 6 months—I believe about 8 months, and I can never find out where I am standing, how much sputum, how my X-ray was, how I am progressing.

Q. Who is your doctor?—A. Dr. Meyst, ward 20.

Q. Are you active or negative now? You don't know?—A. That is what I don't know. According to the way I feel, I am always out on the grounds, and the patients over here to see me—I mean every day and every minute on my feet.

Q. What are they doing for you?—A. The only thing what I got, in addition to this, whenever I want anything they scare me with some kind of house of correction. Supposed to be some kind of court order which I don't know anything about. I have never been convicted in military life, or civilian either.

Q. Who scared you?—A. The office over here.

Q. Let's be specific. Who made threats against you? Who has told you that you would be sent to the house of correction?—A. My doctor told me.

Q. What is his name?—A. Dr. Meyst.

Q. He told you what, exactly?—A. If I don't behave, or anything like that; if I demand, if I get, probably, rough, or something like that, they can put me away in the place I wouldn't like it. "What place?" I says. "You know," he says, "House of correction." Is that a nice thing?

Q. What is the house of correction? Where is this?—A. I have been outside. I got here a little over 3 years ago. Somehow or another I happened to be called to court, and a judge asked me and give a chance to put over here, when I came over here voluntarily myself. Now they claim there is an order against me signed by some judge.

Q. How do you know?—A. The authorities here, they claim that someone signed a warrant—I mean just a court order. I don't know where it really come from, and how I really got in this mess.

Q. I don't know what mess you are talking about.—A. The mess I am in. I am want to find out something about myself, which they never get me satisfactory answer. Then they tell me that I can't talk too much because they are going to put me away.

Q. Please don't misunderstand me. When you say "they," I wish you would mention names. I don't know who you are talking about.—A. Authorities over here in the hospital.

Q. What authorities?—A. Either my doctor—or I have been here in front of the board about 2 weeks ago, and the board told me the same thing.

Q. Who was on the board?—A. A major, I believe, one captain, and there was my doctor, and two other civilians; I don't know who they were.



Q. What were you up before the board for?—A. Sort of a disciplinary.

Q. What did they tell you?—A. They told if I didn't do anything—which I didn't do; if I don't behave myself, or something like that, these authorities are going to put me away to the place which I wouldn't like, the house of correction.

Q. Who told you that?—A. The board told me.

Q. What member on the board?—A. A major on the board.

Q. What is the major's name?—A. I don't know.

Q. Did that scare you?—A. No; it didn't scare me. I am innocent. I haven't done anything to be put away.

Q. Do you think anybody could put you away to the house of correction?—A. There have to be reasons. I have to do something first.

Q. Even though you did, these people would have no authority to put you in the house of correction.—A. They probably don't believe me, when there is that order attached to my folder.

Q. That is an order?—A. Come from the outside.

Q. From some court?—A. Some court.

Q. You don't know what kind of order?—A. I don't know. I never got it into my hand.

(Witness excused.)

ALBERT GULCZYNSKI, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, please, sir?—A. Albert Gulczynski, G-u-l-c-z-y-n-s-k-i.

Q. You are what?—A. Veterans' county service officer in the Milwaukee office.

Q. Do you know this gentleman's case?—A. I think I do. Were you [addressing Mr. Bachora] at the hotel at one time? I was instrumental at getting you in the hospital at one time. I think I can explain part of this about the house of correction. I don't know whether it was used as a threat or not, but in Milwaukee we have a law in Milwaukee County that an active tuberculosis case is not permitted to wander around at large. He either goes into a hospital, if the authorities know about it, that he is active, or he has to go to the house of correction hospital, especially on single cases. They kind of lean backward on the married men because they stay at home, are taken care of, and 9 times out of 10 there is a doctor in attendance all the time. But the single men have a tendency—the landlady finds out he is an active TB and she doesn't want him in the home. She tells him to move. He goes into another place. The result is he mingles with other men, uses the same utensils, and might transmit this disease to others. That is why this law was enacted, whereby an active TB case should be hospitalized, rather than be allowed to mingle at will.

Q. What has that got to do with this veteran [referring to Mr. Bachora]?—A. I am not siding with Dr. Meyst, or anything else, but he might have said, "If you leave here and you are a tuberculosis case, you will either have to go to the house of correction hospital or else go into a hospital somewhere." They are the words that might have been used.

(Witness excused.)

STANLEY BACHORA was examined and testified further as follows:

Examination by Congressman DOMENGEAUX:

Q. Any other contributions; anything else you care to say, sir?—

A. That is about all.

Q. Let me ask you: You say that you have not had an X-ray for 1 year?—A. For 1 year.

Q. And you have not had a sputum test for how long?—A. Well, you count—shortly, 8 months.

Q. Eight months?—A. Now I had one. I made a squawk about it, I would like to find out something. They give me an X-ray and 72-hour sputum test, and I never heard nothing about it yet. That was about 2 weeks ago.

Q. Thank you very much.

(Witness excused.)

Congressman DOMENGEAUX. We will adjourn now until 1:30 this afternoon.

(Whereupon a recess was taken until 1:30 p. m. of the same day.)

#### FRIDAY AFTERNOON SESSION

(The hearing resumed pursuant to recess last above noted, Congressman Domengeaux presiding.)

Congressman DOMENGEAUX. The meeting will come to order, please.

ROBERT ROBERTS, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you kindly give us your name, please?—A. My name is Robert Roberts, Madison, Wis.

Q. And how old are you, sir?—A. I am 35.

Q. Are you a veteran of this war?—A. Yes, sir.

Q. How long have you been in the Wood Facility?—A. I have been here since April, entered on April 15.

Q. You want to offer some thought to this hearing?—A. Well, only constructive criticism.

Q. I am very glad to get that, sir.—A. I was in the receiving ward for 1 month.

Q. You mean when you came into the hospital they kept you in the receiving ward 1 month?—A. Yes, sir.

Q. Why?—A. I really don't know the reason why. I didn't take it as my business to find out why I stayed there, but as one of the patients mentioned this morning that the doctor comes in and makes his rounds and says, "Good morning, how are you?, and so on and so forth, and makes some comments, and formed the impression that possibly he doesn't care or he doesn't know whether they made a history or not. The idea is that, why should one have to stay so long in the hospital before getting to your appropriate ward where they diagnose you?

Q. During the time you were in the receiving ward were you being examined in a diagnostic way to determine your condition and where to send you?—A. I was taken care of on the third day. My history, and new history, was being taken by a doctor. After that history

was taken I remained on that receiving ward, and then finally I was transferred. I don't know whether they were trying to make the diagnosis on receiving ward or not. In the meantime I was transferred down, after a month, you see.

Q. Did that seem to be the general practice, keeping patients there for that period of time?—A. I wouldn't know, because this is my first entrance to the facility here. Anyway, the doctors asked some questions, and there never seemed to be a nurse along with the doctor, and when asking for medications it seemed rather difficult to get them. It was an inconvenience, or something, trying to get an OD to authorize medication when a doctor didn't authorize it.

Q. Are you speaking of any particular doctor, or generally?—A. Generally in the ward. I have been on two wards here in the hospital. Just recently—

Q. Now, we must place some power and discretion in the doctors. You recognize that the medical determination has got to be made by the doctor?—A. That is right. Anyway, I was up for discharge from the hospital twice, and this last time, just within this last week, I was going to be discharged with maximum hospital benefit, while my conditions remain the same, nose and stomach. I wrote a letter to Colonel Mullins, who very gracefully returned and answered that he had called my doctor into his office and recommended that I see a nose specialist and also a stomach specialist, which led me to think that why couldn't we have specialist treatment in the hospital, rather than going outside to get it?

Q. You have to leave the hospital to get specialty work in your case?—A. That is right. I am leaving this afternoon at 2 o'clock to see a stomach specialist downtown.

Q. A stomach specialist and nose specialist?—A. I have been before the nose specialist and he recommended the use of certain medications which I have not received from the hospital up until this time. The last week I was before a nose specialist.

Q. Is this a part-time doctor?—A. I wouldn't know anything; whether he had a consultant for the hospital, I don't know.

Q. Do you know whether stomach cases must be sent to specialists out of town?—A. That is right.

Q. That is the usual thing that is done?—A. I don't know whether it is practiced, but my impression was rather disillusioned when it come about that way, being in the hospital that long.

Q. You don't know whether the shortage of doctors, or the inadequate amount of doctors, or the type of doctors that are evidently not in these hospitals is the result of conditions brought about by the war, or whether that condition has prevailed since the Veterans' Administration has been in existence?—A. A question I would like to ask you, with doctors coming back from overseas—some of them I know are very good, and I have had the very best, excellent medical care overseas; I know of some of them coming back to this country that are being released by the Army—why is it that veterans' facilities cannot acquire these doctors, probably specialists?

Q. I am sure that a very serious effort will be made to acquire these doctors. The salary range and other reasons, in my opinion, in the past have not attracted the best medical talent. You can't expect to attract a doctor when you start him off, originally and formerly, around \$3,200 a year. Wouldn't that be the pay when a doctor first



started?—A. There is another thing I wish to ask now, in getting together. Now, there is confusement to patients where you get doctors together; they make consultations. One doctor will give one diagnosis, and another doctor will give another diagnosis. That leaves the patient up in the air as to where he stands. I think sometimes they are inclined to lose a little confidence in the doctor.

Q. Are you speaking of any particular case?—A. Well, there are cases where the patient—where you come in and one says one thing, and then when you come in with a specialist he says another thing.

Q. As long as doctors are human beings, I imagine there will be differences of opinion. I don't know how you could prevent that.—A. Another thing I think that is a constructive criticism: Just yesterday morning, in the 4 months I have been there, the doctor on my ward made rounds and a nurse was with him—the first time I had seen it done around here; it had been done in Army hospitals—with a tablet, contacting each patient if he wanted any medication. She wrote it down—he had her write it down, and he went to the office—and the history, which I think was a good system to it. There is no question as to whether that patient asked for medicine or not if it is written down in the room.

Q. That happened for the first time?—A. Since I have been here in the hospital.

Q. You don't know why that practice—A. I don't know why.

Q. It could be because of the congressional investigation going on?—A. I wouldn't know that. But I came purely as an unselfish—I plan to get out of here and be well, and the next fellow comes in—we are all working together.

Q. I have had the opportunity of speaking to you personally, and I am satisfied that your motives are good, and you have only the hope of suggesting something constructive for the good of the service.—A. And another thing: I don't know just in my observance of nurses now; we have a lot of excellent nurses—bringing up the point as far as brutality, I have never seen any in the hospital since I have been here.

Q. Mistreatment?—A. No mistreatment.

Q. No intimidation?—A. Probably a little. I think those are minor details. If they would straighten out the major details, the minor would be taken care of.

Q. What are the details?—A. Where the nurse suggests something to the doctor. I think the doctor makes a diagnosis that the nurse complies with. There is just one case—

Q. You don't know that of your own knowledge?—A. I know on this certain ward—in ward 9 that I was on—he went out just in fun. There were cadet nurses there in the room. It was inspection day—Friday—which a lot of us patients like around here. They make a lot of it. I can't see why there should be a special day for it. Why not just the usual routine as in civilian hospitals of keeping the place clean? Ambulatory patients have help with the cleaning.

Q. You would dispense with inspection?—A. Not necessarily. I think they probably could make inspections without disturbing the patients.

Q. Don't you think inspections, even though disagreeable and sometimes inconvenient and sometimes disturbing to the patients, are absolutely essential to the proper running and regulation of a hospital of

this size? Don't you think they are necessary?—A. They are necessary, yes; but as to disturbance and leaving medications go just until after inspection is over—things like that.

Q. You don't think your general efficiency of the hospital should suffer?—A. I think they should go on with them. In several cases it had happened that way. Why it should enter in, I see no reason. Possibly a nurse coming in, being discharged veterans and possibly civilians, and where you have been out a year and already working, and already taxes are being deducted from the wages—you are paying into this place—I would think we could carry on a little bit with giving some credit to men having a little bit of integrity and intelligence about some things. I am inclined to think they don't quite trust us as yet, to a certain extent. They think you are a child. After all, we have our own future and life to make, and I think the proper diagnosis—

Q. You feel more responsibility, or sense of responsibility, should be placed in the patient?—A. I think so.

Q. And there should be a closer relation between the patient and the doctor?—A. That is right. After all, we are all human, on the same level, because the Army took us in as a respecter of no man, and I think we should all work together. And the whole motive of this war is to get rid of selfishness. We could work together in a little better way without stabbing each other in the back, so to speak. If we have anything to say, say it to your face.

Q. Hospitals of this kind are operating, I think you will agree, under a terrific handicap as a result of the war.—A. No question about that.

Q. Many of the doctors, and possibly some of the better doctors of the Veterans' Administration, have been taken into the armed services; a great many of your nurses and a great many of your attendants. I do believe that hospital service has suffered materially as a result of the war, and possibly beyond anyone's control. You believe that that is correct, don't you?—A. I believe that. That is true of anything, especially right now. But I think that we have a good—majority, they have good help here, I mean, in numbers. Possibly at night—now, in our ward this man kept track of his medication when he asked for it. He received it in an hour and 15 minutes. He kept time from the time he asked for that medication. There is one nurse on that ward at night. Ambulatory patients can take care of themselves. When there are sick men needing nurses, it seems to me they should have more than one nurse on a ward. I don't know.

Q. It is human nature, and we are prone to remember those instances that bring discomfort and inconvenience to the patient. Those things that you mentioned, is that the usual thing or is it the exceptional thing?—A. It seems to have been that way as to the administration and the feeling that, well, the head nurse is coming down; they all run to their different places.

Q. That is on inspection day?—A. On inspection or any other day, which I think if one is doing their work well there shouldn't be any of that thing of self-confidence.

Q. Inspection comes first; is that right?—A. I would say that.

Q. Plenty others say that, too?—A. So—

Q. But you don't?—A. That is in all fairness that I say that, because that is my impression.

Q. But you couldn't dispense with inspection in a hospital?—

A. Why, in civilian hospitals? They have some large civilian hospitals. They don't make anything of it—I mean here they come in and they have a doctor, nurse—nurse comes with a towel and goes along and wipes her finger along, and if there happens to be a little dust somebody is liable to get kicked at for that. I don't think that is the proper attitude. They are told sometimes in front of the patient.

Q. That is a matter of administration. There is plenty good can be said on both sides. Cleanliness is absolutely essential. I think it is one of the most important things in a hospital. I think your hospital is exceedingly clean.—A. That is right.

Q. I am not one of those that believes a hospital can be too clean. I think it is absolutely essential and necessary that a hospital be clean. I think a wonderful job in that respect has been done in this hospital.—

A. It is an immaculate hospital.

Q. Some people think that a virtue when overdone becomes a vice, but that is a quotation of my friend over there. Nevertheless we are glad to have your opinion. Is there anything else you would like to contribute?—A. There is nothing else, other than stating—

Congressman DOMENGEAUX. I am very much concerned about the practice that when a man having these conditions you have—and you don't seem to be a very sick man—that you have got to leave the hospital and see a specialist to get diagnosed. Is there any reason for that? I mean, I understand the reason, the fact that evidently you haven't got the doctors over here to do it. Why should that be?

Lieutenant Colonel MULLINS. This case—while I am familiar with some of it, not entirely with all the case—received his examination and treatment was not recommended. He has a nasal condition and he has a gastro-intestinal condition for which hospitalization wasn't recommended. I saw this patient two or three times, and one time I had a letter from him. In order to satisfy him I had our consultant, Dr. Smith, one of the best known specialists in this country, to see him and he also sent you downtown for further examinations. In no case was treatment recommended. Dr. Smith didn't recommend any surgery on the nose at that time at all.

Congressman DOMENGEAUX. Then it is not the rule that you find it necessary to send patients—

Lieutenant Colonel MULLINS. It is the exception.

Congressman DOMENGEAUX. It is the exception?

Lieutenant Colonel MULLINS. That is right.

Congressman DOMENGEAUX. Thank you, sir.

(Witness excused.)

H. STANLEY BLAKE, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Are you ready over there, my friend? Give us your full name.—

A. H. Stanley Blake.

Q. You have been in the home how long?—A. Seven years 13th of this month.

Q. We will be very glad, sir, to get your comments about what you know about the hospital.—A. Sir?



Q. We would be very happy to have your comments about your experiences here and your observations of the hospital.—A. Well, when I came here July 13, 1938, I was comparatively helpless, except for the slight use of my hand, whereas now I am relatively self-sufficient except for buttoning the top button of my shirt and some help—I have to have assistance in taking a bath and a little bit of help in going to bed—retiring. I knew what I had before I came here. I had been told many, many times that it was incurable, told by many doctors, which I didn't—they just didn't know about it. They just said they didn't know about my condition—not my condition, but the condition; there was no help for it. I just came to the conclusion long before I came here if there was anything to be done, that I would be the one that would have to do it. Well, I just figured I had to use what abilities I had, and that was all there was to it. In the 7 years I have been here I feel I have had relatively good treatment.

Q. Why do you use the term “relatively”? Have you had good treatment?—A. Why, I think—yes; let it go at that. I don't mean to be facetious about it. My treatment is the only one I have to judge by. I am not experienced in private hospitals, or anything. I believe that I have had, as I say, relatively good treatment. I do not mean to qualify that by saying “relatively.” It is good treatment as I know it. There have been a few minor instances when some individual, attendant, or some of the fellows who are not here any more, have said—oh, they have done little things in a mild reprisal for excesses, we will say, things for which I was not to blame. But those were individual. I never blamed the institution because of those things. Those were just individual things.

Q. The human element—A. Many of those people are not here any more. I had one doctor tell me, “You can't get well; you can't get well. You might as well recognize it yourself.” You don't care about my opinion, but I just figured that was an opinion.

I could say I have had good treatment here, and I think we have a lot of advantages. I have been here 7 years and have never seen a movie or a show, but that was because of certain weaknesses, physical weaknesses on my part. They were here, they were available; I just never have seen them. We have a wonderful library service here, and all of those things. The librarians are always ready and eager to give research help. I think it is a very fine place.

Q. What is your opinion—you have been here many years and are certainly qualified to speak—as to the standard of food and its preparation?—A. Well, I have thought highly of the food and at different times—I write letters for different fellows unable to write themselves, and I have frequently described the meals we have here, and a lot of people wanted to know if they couldn't move in here. I think the food has been good. I say that without any qualification whatsoever. I say it has been good.

Q. And it has been of such standard over the period of years since you have been here?—A. Yes. A lot of fellows don't agree with me on that, but that is my opinion; that is my opinion.

Q. Have you ever seen any evidence of brutality or mistreatment?—A. No—well, here, one or two I have stated. On one or two occasions—one or two; on several occasions, but I have been guilty of excesses that—I mean physical excesses for which I could be held blameless, but those were individual cases. There was no coordinated

mistreatment nor any official reprisals because of them. I thought that they—here, the doctors say that is fine; that is just natural. They don't say it is fine, but that is all right, that is natural. Unfortunately, they didn't have my personal care. They might have felt differently about it.

Q. Will you kindly give me the facts of one of these instances so I can determine the extent of this lack of consideration?—A. Well, here in 1939 I came over here to the General on May 18 and had several hemorrhoidectomies. On returning I went back with a pressure sore on my coccyx or tailbone. I had been exceptionally weak before that, but that just destroyed any coordination I had, so I was helpless. I had to be fed. Before that time I had been able to sit up and feed myself. But some of the orderlies felt inasmuch as I had been normal before in that respect, that I was just laying down on the job. I had to report them several times in order to get to bed. The nurses were always ready to give aid in that respect, to see that it was done. But here, just a little roughness—no beatings or anything of the kind—just little acts of, well, personal spite.

Q. The human element entered into this picture?—A. Sir?

Q. The human element; that is the result of the human element? Occasionally a person may not feel just right on one day and he will be cranky?—A. That is right.

Q. I don't imagine doctors in the hospital can be happy all the time, nor can attendants or nurses. They have their bad days like anybody else, I presume.—A. That is true.

Q. I know I have mine.—A. I have mine. I have nothing to complain about anything. I told you that I have felt that the treatment I received here has been good.

Q. Have you seen any evidence of intimidation or fear in the minds of the patients or attendants?—A. No.

Q. To the extent that if they were cross with Miss Metcalfe or administration they would be put in the mental ward, or something of that kind?—A. No; definitely.

Q. Never heard of anything like that?—A. No, never. I have stated 6 years ago—I think I did—I was quite helpless except for a small movement of my hand, whereas now I am relatively self-sufficient, almost self-sufficient. However, the margin between one thing and the other is so narrow there is nothing to boast about, but that is the way I am now.

Q. Well, Mr. Blake, I know of the great and courageous fight you have made, and it is largely the result of your own efforts, a very determined and beautiful fight. I have read some of the things you have done, and you have been written about in magazines. I think your viewpoint fills out the understanding of your condition, and these conditions generally are very sound and very good. I am happy to have had you with us.—A. Thank you, sir. I am going to answer that article in that magazine.

Q. Which article?—A. That Reader's Scope. I have lived with these people here, as I say, for 7 years. I just don't think it is fair in any way. I am reasonably alert and observing, and it hardly seems possible that these things could have taken place within range of my vision or hearing without my hearing something about it first hand. It doesn't make any difference what I like, but so far as I am concerned they are untrue.

Q. You want to be fair about the situation?—A. Yes.

Q. As we all should be, and as we want to be.—A. Yes.

Congressman DOMENGEAUX. Thank you very much, sir.

(Witness excused.)

Lieutenant Colonel MULLINS. Mr. Congressman, I have the case record on Patient Lomax who testified this morning.

Congressman DOMENGEAUX. I would like the record on this Patient Lomax, the Negro active tuberculosis case that came up this morning and said he had been put out of the hospital——

Lieutenant Colonel MULLINS. That is right, sir.

Congressman DOMENGEAUX. Because he had overlapped his leave through no fault of his own.

Lieutenant Colonel MULLINS. That is right, sir.

Congressman DOMENGEAUX. I wish you would explain the record as you know it.

Lieutenant Colonel MULLINS. Patient Attless Lomax has given permission to make his record public to you and this hearing. He signed a permission for that, which is in accordance with our regulations. All records are confidential.

Congressman DOMENGEAUX. That is right.

Lieutenant Colonel MULLINS. Patient Lomax has had several periods of hospitalization at Wood, going back for a period of several years. However, for your records we will go back——

Congressman DOMENGEAUX. Colonel, what I was particularly interested in was with reference to his dismissal, his date of active tuberculosis, whether it is true or not.

Lieutenant Colonel MULLINS. That is right. That is what I am leading up to. He was admitted to this hospital on October 13, 1934; was discharged, absent without leave, on December 1, 1944. According to our rules and regulations, a regular discharge prevents a patient from returning to the hospital for a period of 90 days, unless he should become in need of emergency treatment. This man was readmitted to the hospital on the 13th day of December 1944 and discharged on January 4, 1945, as not in need of emergency treatment, after being examined by a special board of medical officers.

He was examined, according to the records, on January 3, 1945. A diagnosis of pulmonary tuberculosis, chronic, far advanced, active 1. The classifications 1, 2, 3, and 4, as we use it, refers to the symptoms. In other words, this man, according to this diagnosis, while he had a far-advanced active pulmonary tuberculosis, had the minimum symptoms that go with that disease. The above diagnosis was based on positive sputum, X-ray findings, and physical examination.

The board further states [reading]:

This man was admitted to the facility December 13, 1944, for emergency only. It is the opinion of the board at this time that he is not considered a medical emergency and can be discharged, not endangering his life.

and the board recommended his discharge, which was in accordance with the present rules and regulations concerning hospital discipline.

Congressman DOMENGEAUX. The regulations from the home office as given to you in which you have no choice or discretion is that if a man is a. w. o. l. he cannot return within 90 days, except being an emergency case?

Lieutenant Colonel MULLINS. That is right, sir.



Congressman DOMENGEAUX. In this case this Negro was returned to the hospital, being a. w. o. l., and at that time he was an emergency, wasn't he?

Lieutenant Colonel MULLINS. He was brought in as an emergency and kept in the hospital from December 13 until the time of his discharge, January 4.

Congressman DOMENGEAUX. Apart from this individual case, which I personally think is severe, in an enlightened world where we all recognize that tuberculosis is very contagious, how can the Veterans' Administration justify discharging men who are active tuberculars, where they may go out and—apart from the question whether their lives are going to be in danger—possibly contaminate communities? It isn't your fault. You are following regulations. Don't misunderstand me. But I can't understand the justification for such a ruling or such a regulation.

Lieutenant Colonel MULLINS. The only justification in a case like this is a matter of discipline.

Congressman DOMENGEAUX. As to his particular case, was it investigated to determine whether or not his story about being sick and having a hemorrhage when he went to Chicago resulted as a reason why he was a. w. o. l.?

Lieutenant Colonel MULLINS. Here is a letter from the social service department, Cook County Hospital. It is dated December 7. [Reading:]

UNITED STATES VETERANS' ADMINISTRATION,  
Wood, Ill.

*To Whom It May Concern:*

Mr. Attless Lomax was admitted to our tuberculosis hospital December 3, 1944, after a severe episode of hemoptysis, or pulmonary hemorrhage. Tests taken on December 5 showed he had a positive sputum. The patient tells us that he came to Chicago on October 28 on pass from Wood Sanatorium and overstayed his leave December 3, 1944. He was too ill to return until his discharge day, December 17, 1944.

Congressman DOMENGEAUX. That bears out his story, doesn't it?

Lieutenant Colonel MULLINS. Yes.

Congressman DOMENGEAUX. And this patient under those circumstances was discharged from the hospital as a. w. o. l., according to the record?

Lieutenant Colonel MULLINS. Yes. He was a. w. o. l. from the hospital. He went home on pass and did not return.

(During the previous discussion, comments were made by those in the audience.)

Congressman DOMENGEAUX. We don't want any comments from the audience; and if these comments continue we are going to put this session into an executive session. We want this thing to be conducted as it ought to be, and no comments.

What I want to get in my mind, Colonel—you don't take into consideration the reasons and the cause why a man may be a. w. o. l., causes beyond his ability to control?

Lieutenant Colonel MULLINS. Why; yes, sir.

Congressman DOMENGEAUX. If we are correct on our facts, this patient while on a pass developed this serious hemorrhage and was placed into this hospital, and that he remained in this hospital in Chicago, and upon being able he returned to the veterans' hospital in an emergency condition.

Lieutenant Colonel MULLINS. If I may interrupt just a minute, he was discharged from the Cook County Hospital on December 7, and he did not return to us until December 14.

Congressman DOMENGEAUX. That is 7 days' interval?

Lieutenant Colonel MULLINS. Seven days' interval.

Congressman DOMENGEAUX. I see; I understand. He was out from this hospital for 7 days before returning here.

Lieutenant Colonel MULLINS. And also away from Cook County 7 days before he returned here. Since that he was readmitted to this hospital on March 3, 1945, remaining until March 9, when he was discharged as a. w. o. l. He was again admitted on May 1, 1945, and he remained in the hospital until May 8, 1945, and he was again readmitted to the hospital just day before yesterday, the 18th.

Congressman DOMENGEAUX. There is the regulation of the Veterans' Administration, from the central office, which allows a veteran who is to be discharged to be discharged even though he may have active tuberculosis?

Lieutenant Colonel MULLINS. Yes, sir. We can't keep them against their wishes. We have no authority.

Congressman DOMENGEAUX. I appreciate that. What I mean is this: The regulations require you, or the manager, to discharge a veteran who is suffering from active tuberculosis if he is a. w. o. l. and his case is not an emergency case?

Lieutenant Colonel MULLINS. That is right, sir.

Congressman DOMENGEAUX. In other words, a veteran with active tuberculosis, who we acknowledge may contaminate others with whom he may come in contact, can be, and is frequently, discharged from the hospital?

Lieutenant Colonel MULLINS. That is true.

Congressman DOMENGEAUX. Is there some danger to a community, or to those with whom he comes in contact—his family and others?

Lieutenant Colonel MULLINS. Yes; certainly; I believe so.

Congressman DOMENGEAUX. Certainly there is some danger to him, too?

Lieutenant Colonel MULLINS. In this State we have a Public Health Act which, if it was invoked, the local authorities could commit a person with active pulmonary tuberculosis to either a hospital or the county workhouse for treatment, or the county hospital.

Congressman DOMENGEAUX. Just to keep the record straight, you gentlemen have no choice in that matter? You are following the regulations of the central office?

Lieutenant Colonel MULLINS. That is right, sir. Each time this man returns to the hospital he is taken in as an emergency in order to give him the benefit of the doubt. That is our record there on six or eight different occasions.

Congressman DOMENGEAUX. If he let the 90-day period lapse he could come in as a regular patient; within the 90-day period he has to come in as an emergency.

Lieutenant Colonel MULLINS. That is right.

Congressman DOMENGEAUX. You don't know what this veteran was doing? Did he make any explanation?

Lieutenant Colonel MULLINS. No; he did not.

Congressman DOMENGEAUX. As to what he was doing from the time that he was discharged from the hospital in Chicago to when he returned here some 7 days later?

Lieutenant Colonel MULLINS. No.

Congressman DOMENGEAUX. You don't know, do you?

Lieutenant Colonel MULLINS. No; I don't know that.

Congressman DOMENGEAUX. Thank you, sir.

WILLIAM F. BRUETT, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, sir?—A. William F. Bruett.

Q. You are a veteran of the Spanish-American War?—A. Yes.

Q. Would you like to testify, sir?—A. I would like to say that I feel it my duty to appear here today to speak.

Q. We are glad to have you, sir.—A. I am glad to do it. My voice is a little bit weak, but I think you will understand me.

Q. I would hate to see you when it was strong.—A. I was interested in this hospital for about 15 years.

Q. How long have you been at the hospital?—A. This last time I come in here last September—December, rather.

Q. You have been here before?—A. Yes; I was here for 18 months. I was badly broken up, in bed a year and 8 months, outside on crutches, and such as that.

Q. Just go right ahead.—A. With my history?

Q. No; no; I am not interested in your medical history.—A. I naturally went to work. I am very much interested in the work. It is something that keeps me busy and something that keeps me away from my own thoughts, that are not possibly right. I love this institution. I think we can thank God that we have got an institution of this kind in this city—absolutely. At the most, I don't think there were over 100 Spaniards here during my visits here at the hospital each week for 15 years, and sometimes four or five times a week. I enjoyed it.

Well, in 1933 I was injured badly, and since then I commenced to take an interest—more of an interest than I did before. I met all kinds of people, and I took an interest in individual cases. I will say one thing right now—there is a certain Spaniard veteran who was doing fine here, doing fine for a month or 6 weeks or 2 months, and suddenly I noticed he was not doing so well. I asked him what the trouble was. "Oh," he says, "my regular doctor took a vacation, and another doctor changed my medicine." That is what he said. He was one of these quiet, conservative fellows, and I asked him if he had told the doctor about this. Well, it was doubtful in my mind whether he said anything at all about it to the doctor. "Well," I said, "we will look into it." I took it upon myself to go to the head office and called the doctor's attention to it. I must say I was received very fine, very fine. They thanked me for coming up and telling me of the case. He said, "We will investigate. You be here at 2 o'clock." At 2 o'clock I was here, and they supplied me with the doctor, and we went all over the case. He says, "We are going to take care of this case for you." I think it was 9 days after they changed the



treatment, or 9 days after I visited this doctor, he left here with a smile on his face and full of praise for the service received here.

Now, I will say that from 95 to 98 percent of our veterans are perfectly satisfied with the treatment received, regardless of the condition of the country today during the wartime, or any other time. I will say that, and say it honestly and conscientiously.

Q. I agree with you. Ninety-five percent of those I have spoken to are perfectly satisfied. That has been my observation.—A. I also want to mention at this time the fine cooperation I received from the officers in charge, from the doctors and others in charge. It really has given me something to think about and made me all the more interested in the sick. Now, I know what some possibly might think: "That old guy, he is an old-timer; he doesn't know what he is talking about. He belonged to the Spanish-American War"—which I have had thrown up to me a thousand times.

Q. My father was a Spanish-American veteran.—A. "You had only a month or two of service; you didn't see any service." I didn't want them to do that.

Q. Had you been born in the last 25 years you would be a veteran of this war. If they had been born in '98, they would have been veterans of the Spanish-American War. Every soldier that went in the Spanish-American War was a voluntary soldier. There was no conscription.—A. That is where we've got them. I love a veteran regardless of whether he is a I or II war veteran. I don't want to mix up with the World War veterans. I am speaking only as a Spanish-American War veteran. I have seen men come in here, and there is terrible discouragement in their face. I suppose they will be carrying me out in a few weeks or a few months feet first. I have seen those same men walk out of here with a smile on their face, just as I said, and full of praise for the service they received.

Now, I can maybe criticize an individual here and there, but before I done any of that I thought the matter over. I think the doctors, between you and I—I think they are overloaded here. I think there is too much work for them. I don't think a doctor should do all his clerical work, for instance.

Now, I enjoy it very much. I am over in Company 8. I have never been to a company before, you know.

Q. Do you think that the management of this hospital is doing everything he can in his power and, generally, that the doctors and the nurses and the attendants are doing those things in their power, with the exception of the occasional case where the human element comes in, in helping out the veterans and the patients at this hospital?—A. I do. I think that we are certainly very lucky to have this institution here. And, of course, an elderly man thinks different than a young man. We might have different opinions, and all this and that; but I think they are short, in this hospital, mental doctors.

Q. Age usually brings tolerance and understanding.—A. I hope so.

Q. And youth sometimes is hard to please.—A. I don't want you to misunderstand me. I have 12 nephews in the Army, and 2 of them served 4 years, and they are glad to be here. I love the soldiers. I love soldiering. I believe in military discipline and courtesy. That, of course, you have to have in an institution of this kind. You have got to have discipline or you won't get very far.

Q. You won't have any institution very long if you don't.—A. I imagine not. I want to tell you about this. I didn't think I could come up here a moment ago. My breathing was hard, and my voice was worse. They said, "You are supposed to have heart trouble, and drop down, or something." I feel fine now.

Congressman DOMENGEAUX. Well, thank you very much, sir. We are glad to have your expression.

CHARLES H. OSTERBURG, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you give us your name, sir?—A. My name is Charles H. Osterburg. I come here first September 24, 1937. I was at Waukesha, where I stayed 2 weeks. I never got any kind of an examination, when I was first sent over there, to speak of.

Q. Waukesha in 1928?—A. 1937. I begin to feel bad, and I complained to Dr. Wood. Finally he took the tumor out of the shoulder. That didn't help matters any. My condition was luetic. Then after awhile I got notice to report to Dr. Dwyer. He is now deceased.

Q. At Wood?—A. At Wood; yes, sir. He recommended that I be transferred to this facility, and I have been in this facility since October 10, 1938.

Q. Are you in the home?—A. I am in Company 8. I have been there for 7½ or 8 years. In 1941 things begin to happen to me. I have been always complaining that I needed more treatment. It is known by the medical profession that luetics need treatment from time to time.

Q. I don't know.—A. That is known by specialists. I have consulted with Clarence A. Lyman, who is one of the first pioneers in artificial fever therapy, in the last few weeks. He said I needed more—additional fever treatments. I didn't know what I was doing. I am getting worse every day. I thought I couldn't come up here today. I could hardly talk. They did take a cystoscope of me and did discover what was the trouble. I have to tell the doctor what to do. I am only a common layman. Why should I tell him what to do? You can read some of these letters what my sisters wrote. My sister has more physical evidence. I have plenty of it. There are some papers in here. I can only use one hand. I can't get those things myself. I also have some evidence against the facility in Downey. It is shameful and a disgrace to the company.

Q. What is that?—A. When I was in Downey and I couldn't get the proper treatment, I proceeded there with the help of my sister. They treated me fine in Downey.

Q. You may be perfectly correct, but does a layman, such as you and I, know what is the proper thing and what is the proper treatment?—A. All I know is what specialists tell me and my own 30 years of experience taking this kind of treatment. I am not a greenhorn. I have been more or less under this kind of treatment for 30 years. I didn't imagine these things, like some of these fellows around here think. Some of these fellows can't even write a letter straight. I can prove it right here. Just recently I asked Dr. Lyman to find out when the last spinal was taken—February 8. The reply came

back the spinal of 1942, October 1—and they are right in there. I told this doctor to write Downey. I said I had one made on February 8, and I finally got the letter yesterday from this here—it is in here somewheres. I can't see good, see? Maybe this is it. This is the 9th. That is a different kind of letter. This is only part of my stuff. I have a pile in my own locker.

Q. Do you think fever treatment in your advanced stage would help?—A. I don't know. I am only a man living in a poorhouse, you might say.

Q. No, no.—A. That is what they call it, and that is what they treat you like. They give you very little consideration in this place. I was put in the locked ward for 25 days, where I couldn't sleep day or night. I was put in 5 days or nights, until my sister got me out of there. I didn't do a damn thing. Why was I put there? I wrote to the manager and I got his reply, and he evades all them questions. He didn't answer a one of them.

Q. I will talk about your case.—A. He didn't answer a one of them. My sister was a World War nurse, and I wish you to talk to her about it. Her name is M. J. Osterburg, Muskegon, Mich., 429 Eighth Avenue. I am going up there and consult her about my present condition. I think there is something different now than my luetic condition.

Q. Have you anything else to suggest?—A. No, sir.

Q. Thank you very much, and we will look at your case.—A. I have something else. In '26 all my things was taken away. I had this watch, brand new watch, cost \$50. I am not rushed with money. When I saw it next time the glass was broke. I wrote the manager the glass was broke and I expected them to pay for it. They haven't paid for it to this day. Here is the bill from National Avenue.

Q. You don't know who broke it?—A. They got it in good condition. When they take it away from me, they are supposed to return it to me in good condition. I have friends of mine who will personally call on Truman, and I am going to do it. I lived myself for many years in Kansas City.

Q. Harry Truman, President?—A. Yes. I lived for many years in Kansas City.

(Witness excused.)

FLOYD E. GIBSON, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you sit down, sir? What is your name, sir?—A. Floyd E. Gibson.

Q. You are an employee of the hospital?—A. Nine years a ward attendant.

Q. What is this that you present to me?—A. That is an attendant's point of view, rebutting a publication of an article that we as an attendant group—we feel it reflected upon the treatment that we are giving our brother veterans.

Q. Who is it signed by?—A. By me, with accompanying list of some 130 signatures, all attendants.



Q. Is that the majority of the attendants on the post?—A. I am positive it was the majority that were working on the day I held the meeting.

Q. Would you want to read this and put it in the record, sir?—A. It is quite lengthy.

Q. I think you should read it. That explains your viewpoint?—A. Yes. Personal letter of mine to the chief medical officer, but approved by some 130 signatures of the same type of employees. [Reading:]

JULY 18, 1945.

Lt. Col. GLENN MULLINS,

*Chief Medical Officer, Veterans' Administration,*

*Wood, Wis.*

DEAR SIR: In the August 1945 issue of the magazine *Readers Scope*, there appeared an article authored by one John L. May, a former hospital ward attendant employed at the United States Veterans' Administration hospital located at Wood, Wis. This article was entitled "The Terror at Wood."

In my opinion, this article as presented, taken as a whole, gave to the people a very erroneous and damaging conception of the actual conditions existing in regard to the care and treatment given to our patients (the veterans of all wars). While I believe in and am positive that the local management not only believes in but welcomes any constructive criticism toward the betterment of care and conditions for the welfare of our former men and women who bore arms as the saviors of our great republic. I resent publicity that without extended explanation is adverse and places in the hearts and minds of our former service men and women and their families a feeling that would cause them to hesitate to enter for treatment at the United States Veterans' Administration Hospital as described by Mr. May.

While the defamation in this article is chiefly directed toward the doctors and nurses, I contend that it is an adverse reflection on the whole medical division, of which I am a minor part. (I use the word "minor" because my coworkers and myself are ward attendants and lay-civilian workers who are not professionally trained, as are doctors and nurses.) But in our part of serving patients we probably are more closely and in more constant contact than any division of the medical staff, and, therefore, if we use whatever power of observation we possess, we become more familiar with his or her condition as to the needs of service. Now, any lay man or woman, without hospital experience—only that which they have gained in their own homes—knows that a person who is ill is not normal and that his demands are not the same as those of a vigorous and healthy person. So in this type of work (caring for the sick and injured) takes patience, tact, and sympathy, and, observing the hospital as a whole, I contend that these attributes are extended by the doctors, nurses, and attendants. If one takes into consideration that there are over a thousand patients with a constant daily turn-over and a personnel of several hundred concerned in the admittance of a patient until he is discharged, it must be conceded the human element enters into the question both on the side of the patient as well as the employee. Therefore, a "grief" or a "gripe" (as it is called in soldiers' slang) is bound to occur. Now, to come to some of Mr. May's more pertinent misleading statements in this article, I wish to comment.

1. His first case of Jerry with the broken leg who says he had no attention for 2 days. Every patient in this hospital has his temperature taken by a nurse at least twice a day, and his ward surgeon makes bedside rounds each morning and is on call at any time if the patient's condition justifies more constant attention. Now I am not an M. D., but common reasoning tells you not even a first-aid man, let alone an M. D., would rebreak a leg without anesthesia if it were available, and it is always available in a hospital.

2. "Men whimper and moan and go mad at Wood": The answer is—children who are not even 6 sometimes whimper and moan. As to the going mad, that is a mental state that can hardly be prevented and not caused by any lack of treatment or attention.

3. Labor union: I do not believe the public is vitally interested in our working conditions, even though they should be, as it makes for better service to the patient to have a satisfied employee waiting upon him. But just to keep the rec-

ords straight, the United Federal Workers of America, Local No. 88, CIO, was formed in 1938, not 1941, and as a charter member I can safely state that through the efforts of this local many bad working conditions have been eliminated or improved and a harmonious relation established between employees and management, and eventually our achievements will be greater.

4. Miss Ruth E. Metcalfe, chief nurse: I have never heard Miss Metcalfe tell any employees to keep their mouth shut in regard to conditions at Wood, nor do I believe you can find anyone who will verify such a statement as coming from her.

5. As to Mr. A, an X-ray operator: I am personally (through the union local 88) familiar with part of his case but refrain to comment upon the particulars as this would probably be harmful to him and would accomplish no good, but, in Mr. May's article, he infers that Mr. A's opposition to Miss Metcalfe was the cause of his predicament. Miss Metcalfe has no jurisdiction over the X-ray department and I am sure she was not even interested in Mr. A's case, and if he was taken out of the State of Wisconsin and "dumped" into Illinois, it was not done by the United States Veterans' Administration, Wood, Wis.

6. Mental patients: As to mental patients being chained, there is nothing can be said strong enough to contradict that statement, as over 9 years of ward attendant experience at Wood, I nor anyone else has ever seen a chain used on a patient. There is a cloth jacket, or a bed sheet and bed sideboards used when a patient becomes violent for his protection as well as for the protection of his fellow patients in the same room. But this is practiced in all hospitals, both private and public.

7. At no time have I ever seen a patient unduly left to lie in his own blood and excrement, nor is there at any time a lack of baths and use of oils for patients with bed sores. In fact, patients with bed sores get unlimited attention pertaining to their bed sores.

8. Doctors and nurses: I am not qualified to comment upon them, as I am writing on only those subjects that pertain to attendants and their casual observation, but would add I have never heard a doctor refer to a patient as a "dirty Jew" or a "damn Nigger." At Wood we have approximately 50 doctors treating thousands of patients so is it anything unusual to have an occasional wrong diagnosis? In private practice I feel sure the percentage is much higher.

As to the conditions in general, there is lots of room for improvement and some of Mr. May's statements are correct, but what institution of this size cannot be improved, and this letter is in no way to be construed as a whitewash for unfavorable conditions. But to put an article like he has written before the public in the manner in which it is presented and the inference to be drawn from it is an over-all unjustified criticism, which I as an attendant giving the best of my ability to my fellow veterans and doing what I consider my home-front duty toward winning the war for democracy I am highly resentful. If an impartial investigation of each patient were possible you would get at least 90 percent favorable with a possible 10 percent dissatisfied, which I consider a wonderful record for cases involved in this institution.

This afternoon, July 18, 1945, I am holding a sanctioned meeting of the attendants personnel for the purpose of refuting this unjustifiable attack. In conclusion I give you permission to use this letter to any purpose you may see fit (such as through channels, publication, etc.)

Respectfully yours,

FLOYD E. GIBSON,  
*Hospital Attendant.*

P. S. The following attached signatures are of ward attendants whose length of service at Wood, Wis., is from a few months to 24 years and have approved this letter with sanction of the last paragraph.

I want to state here there was no pressure brought to bear on them. I asked the chairman of the committee of self-appointed men—I asked permission—one of the members of the committee asked for permission for that meeting. They were told before they signed what was going to be done with it. It was written directly to the manager to see just what they seen fit, and if they approved it the sheet was there for them to sign. If they went out and didn't sign it, after working time or for personal reasons, it didn't matter.

Q. This is the result of your thought subscribed in by some—A. One hundred and thirty-seven.



Q. Did any of the administration officers suggest this to you?—A. The letter was given to Colonel Mullins. I left it on his desk, and the paragraph explains what he can do to it, and he told me I could bring it to the Congressman.

Q. Did anyone suggest that you testify at this hearing?—A. No, sir.

Q. Anyone suggest that you not testify?—A. Mr. May intimidated me to the fact that I had better not present that if I knew what was good for me.

Q. When did he do that?—A. This morning's session just after adjournment, before the press.

Q. How did he tell you that? I am not investigating Mr. May, and I have no interest in what Mr. May does or doesn't do, but just for curiosity, what did he tell you?—A. For publicity, I will give it, not to satisfy your curiosity.

Q. Well, yes.—A. He told me I had better start immediately to find a new job. When I got through, I was done. Whatever I had in my hand, if I knew what was good for me I hadn't better present it.

Q. I don't want to get in any contact with Mr. May, discussing his point of view. Thank you very much. We are glad to have you.

(Witness excused.)

ELIZABETH MILLER, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, please?—A. My name is Elizabeth Miller.

Q. Are you an employee of the veterans' hospital?—A. No, sir; I am not an employee of the veterans' hospital, but I have been a patient here five times.

Q. At the hospital?—A. Yes, sir: in the last 9 years.

Q. In what capacity were you able to be admitted?—A. The first time I was brought here as an emergency case, although it was—

Q. I don't mean that. Have you had previous connection with the service?—A. I am a veteran of the World War nurses, First World War. The first hospitalization was more than 3 months, and I received the most marvelous care than anyone could possibly hope to receive anywhere, in any hospital. I don't care where they go. I couldn't walk, I couldn't turn myself over, and I couldn't get my hand to my head when I was brought in here, and after 3 months of their marvelous care and treatment I haven't a limitation of motion any place in my body, nor have I any deformity of any joints.

Part of my treatment during those 3 months was exercise, and I walked up and down the ward day after day all those months, and I had a chance to observe many, many things. And if I were called upon to take an oath, I would have to say not once during all those 3 months did I see or hear of any case of neglect or abuse of patients. I talked with many patients, too, and I heard no complaints, and it doesn't take a nurse 3 months to find out whether or not she is receiving good care.

Q. Thank you very much. Continue, please.—A. I have been back here, as I say, four times since that time. Two years ago I underwent a very critical operation which nearly cost me my life, but through



their skill and immediate attention that life was saved for some reason or other, and I am mighty glad to come up here today to testify in behalf of the staff, from the manager on down to the last attendant, who ever so much as brought me a glass of water. I have only the highest praise. I could go on for hours about the splendid things I have had done for me, but suffice it to say I am here today a normal and well person. I have taken the stand for this administration before on other occasions. The only way I can repay them for all they have done for me is by my loyalty, and they are going to have that as long as I live, to my very last breath.

As far as the food is concerned, the first few times I was in there I am willing to admit I couldn't have as good food as that in my own home. I never saw so much chicken, ice cream, and steaks in my life. Now, however, due to the war, the food isn't as good as it used to be, but it isn't as good anywhere in the world, so what could you expect here. As recently as last December I could offer no complaint about the food. It was sufficient, a good variety, well served, and no flies in it.

Q. You didn't see any flies in it?—A. No flies.

Q. Any observations—I think you are doing very well.—A. I have observed a lot of things, of course. I mean, as I have said, I have been around the wards. I have been back and forth on the runways for weeks at a time.

Q. Do you know Miss Metcalfe?—A. Yes, sir. I know Miss Metcalfe and I know Miss Petty, and I know very many of the other nurses on the staff.

Q. You being a registered nurse of World War I and evidently having had quite a bit of experience, what is your opinion as to the professional qualifications of these two ladies?—A. I think I have never met two finer women, or two finer nurses, in my whole career as a nurse. They are perfect ladies in every sense of the word. As far as using the expressions of "sticking your neck out" and "keeping it under your hat," they just don't use those expressions, because they are not the type of women given to using those expressions. I think the article published in the Reader's Scope is the most vicious thing I have ever read, and I doubt very much it is going to stop at even this investigation. I see broad smiles on the supposed author back there, but that doesn't frighten anyone.

Q. Why did you say "supposed author"?—A. I would rather go into that on the outside, if I may. Mr. May allows this article to be written. I don't think Mr. May would be quite capable of composing a magazine article, to begin with, from his mental condition as I know it, but I was told that he had a ghost writer from that magazine. What they hoped to gain by it I haven't the least idea. Nevertheless Mr. May has taken the credit, if that is what you want to call it, for having written this article.

Q. Credit or discredit?—A. Discredit I would say to himself, only because he cannot discredit the staff of this hospital no matter what he does. They have too good a standing in the community, and I think there are stronger forces than Mr. May that are backing this sort of thing and they are going to see it through.

Q. You have read some of the other articles published in Cosmopolitan?—A. Yes, sir. I read the articles published in Cosmopolitan. They didn't mention the hospital at Wood. I am not in a position

to go into cases, individual cases that are supposed to have had mistreatment or of any of the hospitals mentioned in the *Cosmopolitan*. I do know the things published in this article are the most vicious untruths I have ever read.

Q. I don't think you will find abuse or mistreatment that is condoned and approved, and that is not corrected as soon as possible in any veterans' hospital in this country.—A. I don't believe so, either.

I also had a major operation at the hospital in Hines in 1939. I received the same good care and treatment, and a marvelous piece of surgery. The doctors can verify that. I was very well satisfied there. They gave me the most marvelous care, splendid doctors and wonderful nurses, and I came away after 6 weeks very well satisfied. I think that prevails throughout the veterans' hospitals so far as the management and officers of those hospitals are able to give.

Q. Have you seen any evidence of intimidation or fear?—A. None whatsoever.

Q. That has resulted from the activities of the management here?—A. No, sir.

Q. In trying to intimidate patients?—A. Never.

Q. You don't think it exists?—A. I couldn't believe it exists. I know it doesn't exist.

Q. I want to thank you for coming up. If you have anything further—A. We have some other World War nurses here. There were two other World War nurses. There were seven of us here this morning who have all been patients in this hospital. Others couldn't stay because of duties this afternoon. They did wish their names might be put on record as testifying to the splendid care they had, three of them that are here and the four that had to leave, as verifying the statements that the care here is excellent—all nurses that should know what they are talking about.

Q. What are their names?—A. Mrs. Sue McDermott, Mrs. Bess Loofburo, Miss Agnes Mahon, and Mrs. Anna St. George. They all authorized me to give their names to go into this congressional record as being perfectly satisfied with the care they received here during their period of hospitalization. We have two others here that would like to testify.

Q. Just one question, please. While you have been here on these various occasions, what would you say is the attitude of the average patient, and how does he feel about the care and treatment he receives?—A. I think the average patient is more than satisfied. Of course, it is impossible to satisfy everybody at all times, and I think when a person has spent many weeks, perhaps, in a hospital it becomes very monotonous and they are apt to be disgruntled over little things. I think the big things so far surpass the little things they shouldn't be given notice of at all. We could all make little complaints if we wanted to. I think with the excellent care this hospital gives, it doesn't behoove any of us to criticize the little things. If there are any big things to be corrected, they have a legitimate excuse for complaint, but I have failed to see any.

Q. In other words, in your opinion it is the isolated case that may occasionally creep out as a result of the human element that is glamorized and sensationalized and made big?—A. That is right.

It is the way the thing is worded that makes it sound just what it isn't.

Congressman DOMENGEAUX. Thank you, ma'am.  
(Witness excused.)

MARGARET MEANY, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, ma'am?—A. Margaret Meany. I have come up here in behalf of Miss Metcalfe. I have known her for many years, and she belonged to the District Nurses Association.

Q. Miss Metcalfe who is the head nurse at Wood Hospital?—A. Yes. I feel she has done—has always been very fine in her relationships with the people in the nursing profession. For that reason I feel—because I have been active in the nurses' organization for many years myself, and I feel for that reason—many of us know her and she is known throughout the United States because she has worked in many of the veterans' organization, or veterans' facilities. For that reason, I feel it is a great injustice to her to have an article printed where names are mentioned, at least.

But I was out here as a patient myself a year ago last February. I had pneumonia. It was the second time I had pneumonia. The first time it cost me a great deal of money because I was sick quite a while, but I didn't have sense enough to come out here at that time because I didn't think about it, and went to a private hospital, not realizing. The second time I came out, and I had to be brought out as an emergency case in the evening. I certainly received every care. The only thing that I did want to complain about, I got too much to eat; didn't lose any weight, and I couldn't eat when I went back because I had to keep my weight down. That was the only thing. I never saw better care. I was a nurse in active duty. I am working all the time. For that reason I know what it is, and I have worked in different hospitals. Although I do have a regular position, I worked in hospitals during the infantile epidemic last year to help out. I could get somebody to relieve me and I was not afraid of infantile paralysis, and I went out to help the hospitals. I know the care given here is just as good as it is in any other hospital. I didn't find anything wrong with the food at all. It is very fine.

Q. Yes. Any other observations you wish to make? Did you ever see any brutality or mistreatment or intimidation in this hospital?—A. I was up on the floor where the heart cases are. They seemed to be all getting very good care. I carried health insurance which cost me quite a little bit of money, and I dropped that afterward because I thought if I could get such good care out at Wood I didn't know why I shouldn't. I have heard an attorney say that same thing. I felt the same way.

Congressman DOMENGEAUX. Thank you very much, ma'am.  
(Witness excused.)

HERMAN E. STOLL, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you give us your name?—A. Herman E. Stoll.



Q. Where are you from, sir?—A. Chicago. I heard an opinion here this morning, heard a lot of this conversation about the mistreatment, and so forth. And I have been in this hospital in regards to my illness last year and this year, and I have been in the best hospital in Chicago, bar any, and I can truthfully say I have been taken well care of here, and from the chief medical officer down, and I will give credit that I am here today to the nurses. And when I say I was in the best hospital in Chicago, I will name it—the Passavant Hospital—barring none.

Q. That is a private hospital?—A. That is a private hospital, and if I were to come into a hospital again I would take Wood, Wis.

Q. You compare it favorably with a private hospital?—A. I do; yes. That is why I am here today, and I am only too glad to be up here to say that.

And then in regards to the food, I don't know, I maybe—I didn't get the proper food on the outside, but I am putting on a lot of weight and find it very hard to take off.

Q. Is it tasty? Is it well prepared?—A. I couldn't get any better at home. I came up here on my own accord.

Q. Has the food in the last 3 or 4 days been about the average food that is served?—A. There are exceptions. Everything is all right. As a rule I can't complain. It seems to agree with me. The doctor says to take off weight, and I find it very hard, but somehow I just can't take it off. Maybe it is the resistance of the food that keeps me there. I can truthfully say—I am very sincere in my words; as a matter of fact, I can't express myself clearly at this time that I got the best of care right here at this hospital at Wood, Wis.

Congressman DOMENGEAUX. Thank you very much.  
(Witness excused.)

FRED BAIRD THOMPSON, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your full name, sir?—A. My name is Fred Baird Thompson, Rockford, Ill. I come up here to make a few statements. There are some good, some bad.

Q. Yes.—A. It has been my ill luck, or on account of sickness, to have to be in many of these hospitals. I was transferred here from Dayton, Ohio, a year ago, and I was at Dayton 1 year. Then I was at Outwood before that, and I have been at Hines. Now, the usual questions to a patient that travels around so much are: Were you thrown out? or Did you drink? or Did you go under the fence? For 11 years I have been in these hospitals, and at no time have I broken regulations on these wards or in these hospitals. I don't drink. I have a disease that patients who contract are not supposed to live very long, but I lived longer than they expected me to. That is the reason I am here to be able to say what I am going to say. You won't find many men of my age up here with tuberculosis that can tell the conditions in these hospitals back in '33 or '32, or '35 or '37. Some of the young boys that are here today have only been here a few weeks or months. They haven't been here long enough to know what the conditions were. I am not talking about the conditions alone during the

wartime; I am talking about conditions when the Roosevelt administration come in, if you can remember that far back, around the economical cuff when I landed in these hospitals, and I have seen lots and what I say is so, because my ward doctor, who was here all winter, never questioned my word on anything.

Q. Will you kindly compare, because I think you are very competent to do that, the conditions in tuberculosis hospitals today and in 1933 when you got in, comparison as to the treatment, as to the care from the doctors? Would you care to make that statement?—A. Yes; I can say something about that. Of course, during peacetimes, before the war, most of the men that were patients were Spanish War veterans. We World War veterans knew them as Spaniards, and we were friendly. I was here when there were Spanish War veterans on the ward. I was here at the time when they gave their pensions a raise. I seen them go out from there. They were tickled to death, not because they were against the hospital, but because it gave them freedom and a chance to live outside. But the conditions then—I admit it wasn't as crowded as it is now. This war is bringing in the new war patients, with the old mixed in, and it has drawn doctors out of these hospitals. But the conditions, what I said, there were good and there were bad conditions in these hospitals.

Some of the good things that can be said for the Administration is this: That they are taxed with patients and they are covered over with work, and the Army has taken up a lot of the crack surgeons and doctors. Doctors are classified. My grandfather was a doctor, and my uncle was a doctor. I was raised in a doctor's family. That is all I heard was to give somebody medicine. So I know what the difference is between a physician that can go outside and hang out a shingle and make a living and the salary given in this Veterans' Administration, which is low. It is hard to get a crack physician, or first class, in these places. Right down at Rockford Dr. Murch can make as much in 1 week as these gentlemen in these hospitals do all year. I talked to him personally. He has nothing against the Veterans' Administration, but it is just a salary condition. This crowded business has held up work, and a lack of doctors, and help all the way around, and surgical tools. I have seen conditions in peacetime practically the same as now.

That is what I want to bring out. I want you to understand that this is my opinion; I have no personal grudge. The facts that I want to bring out, these few bad things I have got to say—these conditions here in these hospitals have not always been brought on by wartime. I said to my ward doctor I didn't want to bring my case up. I have had 11 years of it. That is a long time. My case, for example—I will just take 2 or 3 minutes for that.

I went in Hines Hospital in August of 1933. I stayed there nearly 3 years. I know those doctors. I know the doctors, most of them, over there now. Most of the doctors there were dead. I have outlived them. I have been lucky. They told me rest would cure me. I tried 3 years of it, nearly. At the end of that time—Hines was a little low. I transferred here on account of catching a cold and getting a little arthritis. I will say for this hospital—I had been here about 4 or 5 weeks and I hadn't slept; I had always wanted a collapse after that first 2 or 3 years from 1933 to 1936, but it has always been over the hill all these years, and through no fault of mine. I never left these hospitals, as



some boys do, through family ties, or just because of some other reason of that kind. I left it to go to try to live, so I could get in another hospital to get some surgical work. As my mailing address will show, I spent my winters down in Florida to keep alive until the war come, and I have never been able to get down there since. I have had to give my car and trailer up. That is how I lived, down in Florida in the winter and come up to Wisconsin in the summer. This war cut that all out.

Three years ago I had a case of bronchopneumonia. I pulled through that. The first place I had to go was at Wood Hospital. I was still after that air or pneumothorax or phrenic or a rib—anything—because these surgeons on the house side—the best in the country—consulted. Dr. Murch has been head in the clinic in Illinois for years, and a personal friend of mine, told me that my condition would never be cured until I would have a collapse. I have had dozens of doctors tell me that. I have had doctors tell me since I have been here 11 months and 3 days. So they told me it was my salvation, that I had a horseshoe around my neck, or I wouldn't be alive. Wouldn't any man try to get some surgery done or air or a phrenic in all this time when they told me I had a good heart and good stomach? You can see I am not ready to fall over. Any of the boys will tell you I am strong, outside of that lung. Well, I landed because this place was full—I felt this was my second home because after I had been over to Hines, when I was transferred here—outside of the surgical attention or the air, I was treated fairly well through other methods. But the very thing I want done, I never get done. So I tried to get back here in 1943. In July I began to have small hemorrhages. I had hemorrhaged for years, not enough to throw me down, but enough to keep me so I couldn't go back in work that would keep a man in good living and good quarters and not hard labor.

I was told that this place was being remodeled and was full of patients, and I would be sent to Outwood. I objected to that. Of course, he is not investigating Outwood or Dayton. I am giving the conditions in these other hospitals. This hospital in Dayton, in Outwood, I lay in there—they put me on ward 5 with men, every one of them, dying—what I mean, dying. They carried them out. For 8 or 9 days I never had any sleep. I asked for my clothes. I said, "I am going to die if I don't get out of there." The surroundings and the morale of a patient that needed collapse and surgical attention in ward 5, which is the kick-off ward, was beyond reasoning. The rest of them weren't able to get out of bed or hardly move, but I could go to the washroom. I told this marine doctor, "I will pay my way to Dayton because Outwood has no surgical service." This morning I heard stated that Hines was the rib section. That is so. That is the center—that is the center for a lot of hospitals. Imagine Hines trying to take care of Wood, Dayton, and Outwood, the only hospitals of any size in the Middle West out here, and they are all filled up. I thought at the time Dayton had these surgeons.

Q. I am very glad to get all this, but let's get down to facts. You know what I mean.—A. What I want to bring out, that there are no surgeons for chest surgery at Dayton, Outwood, or here. The man contracted here is an outside practitioner. He hasn't shown up yet. They didn't say he would come. He hasn't come. Only a few weeks ago they started clipping adhesions. For those who don't understand,



you have to clip adhesions to give air to some patients to get a full collapse. Since this story in Washington there has been some gradual changes. There have been more phrenics given in this hospital in the last 3 to 5 weeks than there has been in 8 or 9 months before. They are pouring them through now.

The condition in this hospital is the same in other places, too, being crowded. Now, there is 94 patients average on that ward 17 all winter, and I am telling you the truth. Dr. Kristjanson is a conscientious man, but he is an old man. He is 70 years old and shaking like a leaf, and off part of the time on account of his own physical disabilities. Imagine an old fellow like that taking care of 94 patients. They were chest surgery patients.

Q. I don't know this particular case, but you will recognize that the war has made it necessary to use every available doctor that may be found anywhere, because the Army and the Navy have taken in most of the doctors, and particularly the younger doctors. Do you think that the war has something to do with a man being kept out?—A. It has something to do with these cases all piling up, but there were cases previous to the war, similar to myself, that were never taken care of. All through these years I have fought for a collapse when the doctors told me my other lung was good. They would say, "Well, we will get to you." But I waited months and months, until 11 years has gone by, and right now—I came in a year ago. I told the doctors, surely, I would check in in a hospital and spend all that money and come 400 miles, and all of that, just to come in here to be in a hospital. I came in here to get well and get out of here. The ward doctor at Dayton told me to come here and state the case, and get it as soon as possible, because I was a hemorrhage case and he said it shouldn't be delayed. He said, "Ask for a transfer. The board here just won't act." In fact, I was there 1 year, and 76 men, and not one man was sent out of that hospital and got a rib operation. Out of that time I was the only man, except one man that died, that received air, and they did that for emergency for 3 weeks to stop my hemorrhages, and it did stop me.

Q. Just a moment, my friend. You are making general statements there. Do you think you are fair when you criticize generally the medical treatment that these doctors have been giving you? It may be true, but are you competent to determine whether these 93 other patients were being given the proper treatment in accordance with their diagnosis? You don't know that, do you?—A. What I said about this one doctor trying to take care of them was just that he was overworked, but I do know cases that checked out of this hospital.

Q. No; but you are criticizing the medical treatment.—A. I am criticizing the delay of chest surgery, and other collapses of the chest. Such men as Huebner, who had a bed next to me, waited 8 months, and he was working for an insurance company, and they said, "You are a vital man. You get a collapse and you will be out of here." They took him to Saranac Lake to have it taken care of. It took 8 months. He was boarded early, but the red tape, as they call it, and the letters delayed action. I am not criticizing the doctors.

Now, what I want to get to—along about April they brought in Dr. Guilbert, Chief Medical Officer, the TB service. There is a competent man. He came in here at the time these patients had all

piled up through no action on them. He was wading through them and doing what he could. At present we have got a new ward doctor. He has only been there a week or so. Just to show you, in the month, of June we had four different doctors up there in as many weeks. In fact, I don't know their names, and I'll bet there isn't half of the patients in our ward knew the names of those doctors, they came and went so fast. They just come in there a few days and are gone.

Q. That was on your ward?—A. On my ward, on ward 17. Now we have got a doctor, an Army man. They are stationary. That time was just a time when a lot of these cases were on the fire, and they had waited a long time and some of them began to check out on account of the delay on our ward. I am talking about collapse cases, see? We are collapse cases and have already been boarded as collapse cases, not suppositions, understand? These men—they left because they didn't want to delay any longer their treatment.

That is why I say I don't blame these hospitals for being behind with crowded conditions now. I do say they should have had some kind of a man like Guilbert here awhile back. They didn't have any man like him at all here. They never had any chest surgical expert on our ward. They had a chief medical officer here, and I never saw that man until the day he left. He was in his office all the time, and I never even got to look at his face. If I did, I thought maybe he was an employee of the hospital some place else. This man Guilbert is every place.

Q. What was he doing, writing reports?—A. He comes into the ward and interviews the patients personally. I wouldn't have this done now if I hadn't gone to Dr. Guilbert in April and stated all my troubles, like I stated it now, how I went from one hospital to another, and the boards approved that I have these collapses and I couldn't get them. When I went in—you would go before a board—they said, "You should have had that years ago." I stayed there a year. I got out of there, and other conditions made it—

Q. Have they given you that surgery since you have been in this hospital?—A. This is what I am going to say—I was going to get to that: Here, all this winter and all spring, they have been telling me that I was going to get this operation. Well, they started to write letters back and forth with Hines, and they are still at it and still taking X-rays. This board has already boarded me here. I don't blame this institution for that, for Hines holding it up now, but until Dr. Guilbert come just a short time ago, why, it was the first time I had had any action after all this time. I am just stating my case there to show you—

Q. Thank you very much.—A. Here are some of the good things. I will read this and not talk any more.

(Witness Thompson then read a paper he had prepared, which the reporter was instructed to omit from the record.)

Q. Have you seen any brutal treatment or mistreatment of patients?—A. I have seen no physical brutal treatment. There is a treatment, as everybody knows, that is much worse than being pushed around. It is the mental attitude of some nurses toward patients. Now, understand, I have had—there are some nurses here—and these nurses know who I mean, that they know—that I think they are as



good nurses as there is, and they are in the majority. What I am speaking of is isolated cases. If I was asked, "Have you heard of any case, do you know of any personally, or seen it?" this is what I say: You ask about, well, the mental attitude toward patients. What do you mean by that? I mean an antagonistic attitude. They word their statements toward you that aggravates you in a case like this—this happened, and I seen and heard this.

Q. Is that one of the isolated cases?—A. This is one of the cases. This was on Sunday morning. The patients have sputum-cup change and water Sunday morning. They are not changed from the evening before. They were not changed. This patient went to the nurse and asked her if she would have the attendant to put water and sputum cups, that they had been overlooked. The nurse jumped up out of her chair, and here is her words—this the doctor knows of that was on my ward: "Is it a crime to not put fresh water for bed patients, or a penal offense?" I says, what I heard, that it wasn't a crime; it was neglect. The reason for this incident was—it was no fault of the attendant who was a lady. She had been taken off of her regular routine and had been given a job of polishing or buffing the floor, and took her off of her regular routine. She couldn't take care of the fresh water or all these sputum cups. Anybody in a TB section knows what it means to let those sit around. This nurse became furious and made this statement.

Q. What did she say?—A. She says, "Is it a crime to not put fresh water to bed patients, or is it a penal offense?"

Now, the other case is this: Anyone knows a patient should clean a throat spray, or anyone else. I have had one at my bedside for 2 or 3 months. At first it was sterilized, but finally it wasn't. I went up one day and I said, "How about this throat spray? I believe it should be sterilized or cleaned, or something else." This nurse told me that—here is the words: I won't repeat only what she said: "Do it yourself. Don't bother me." Since then I have been washing this throat spray myself in hot water and soap.

Q. Those are the two worst instances that you have seen or experienced?—A. Those are just isolated cases, and nothing—in other words, the conditions here as far as the nurses are, towards the patients in general are very good. And I want to say this: I have et at these other places—and not 10 years, just a few months ago. If you go to Dayton you are going to lose some weight. I did. I come here and I gained weight. Down at Outwood the food is fair, but not like this place.

Q. The food over here is pretty good?—A. The food over here is better than any Veterans' Administration I have ever seen. I have been at Hines, Dayton, and Outwood. That is the truth. I know patients right now in Dayton that would give their right arm to transfer out of there and get here. I know patients at Outwood the same way. This place is full, and they had to send a lot of Chicago patients down there. Of course, the Chicago group want to get in here. I am not saying that just to fool somebody. It is the truth.

Q. Thank you very much—A. I want to give you some of the other—

Q. You have been up here quite a while.  
(Witness excused.)



Mrs. JOHN H. MOSS, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman Domengeaux:

Q. Will you give us your name, please ma'am?—A. My name is Mrs. John H. Moss.

Q. You are a Gray Lady?—A. I am a Gray Lady. I organized a year and a half ago 250 Gray Ladies. We operate in both hospitals. We have 15 groups a week.

Q. Both hospitals, you mean?—A. The annex 2 and the General Hospital.

Q. Both at Wood?—A. Both at Wood. And I want to say that we present love, kindness, service, everything that we can do to make the boys happy, and that is what we strive to do in every way that we can. We are in every crack and corner of both hospitals here at Wood. A great many of our Gray Ladies do a great deal of feeding, particularly in annex 2 and, as a civilian, I think we have a very outstanding representation of civilian women. At no time have I ever heard of any cruelties, or have I seen any cruelties. It has always been a splendid cooperation. I don't say that sometimes things might not go wrong. They do in our own homes. We many times hire help and the help is highly recommended, and we discover that later on they don't work out as they should, but that is not my fault nor is it the fault of the executives.

Whenever we have had an occasion here at Wood and something might have been wrong, we have always taken it to the executives and they have been extremely cooperative, from the manager down through the nurses, and I must say that I have never heard Miss Metcalfe at any time use any of these profane things that she is supposed to have said. We, as Gray Ladies, are supposed to be under the superintendent of nurses. Consequently, I see a great deal of those nurses.

I think we all make mistakes, more or less, in life. We can't any of us be perfect. Sometimes, as you have said before, there are days when people are on edge and sometimes they don't feel so good, but I think as a whole I can say nothing but the very highest of praise for those operating here at Wood, and I am quite sure that we are in a position to see all of these things, and I would be very happy to answer anything you would care to ask.

Q. Your great organization is composed of voluntary ladies who give this service?—A. It is.

Q. And you have how many at Wood?—A. 250.

Q. I see. And you have organized that group?—A. Yes. We have been here a year and a half.

Q. Do you know of any members of your organization, the Gray Ladies, who have observed themselves or who have reported any acts of mismanagement, mistreatment, brutality, lack of consideration?—A. Well, once or twice there has been a report of a little lack of consideration, and I have taken it immediately to Colonel Mullins, and Colonel Mullins and his staff have immediately taken it up and gone through it and corrected the situation.

Q. You feel that the authorities under no circumstances would condone any act which was not completely considerate of the welfare of the patients?—A. I certainly do not. I think they have been very

kind and very considerate. Of course, as outsiders not having any salary to receive, we do our work for the good of the men, and try to bring them all the happiness we can. We would have no reason whatsoever only to give you the absolute truth, and I feel that it is wrong to condemn the executives and their staff.

As far as this article of Mr. May's, I think it really is disgraceful because, naturally, the public doesn't understand those things on the outside.

Q. Thank you very much, and we do appreciate your coming, because we know your expression is certainly one where there is no interest involved. You all have done and are still doing a great, magnificent work for the welfare of the veterans throughout the country.—A. That is what we hope to continue to do.

Congressman DOMENGEAUX. Thank you, ma'am. Glad to have had you.

(Witness excused.)

Congressman DOMENGEAUX. Mr. May, would you like to testify now?

Mr. MAY. Not at this time.

Congressman DOMENGEAUX. Mr. May, you know we would like to accommodate you.

Mr. MAY. I know you would, and I appreciate the fact that you would like to accommodate me, but I am not ready to present any testimony.

Congressman DOMENGEAUX. Could you give me an idea when you would be, sir?

Mr. MAY. After I have been served with a subpoena.

Congressman DOMENGEAUX. After you have been served with a subpoena?

Mr. MAY. I have to get some advice on it afterward.

Congressman DOMENGEAUX. Legal advice?

Mr. MAY. Absolutely. I am not coming barehanded.

Congressman DOMENGEAUX. Sir?

Mr. MAY. I am not coming in barehanded.

Congressman DOMENGEAUX. Let's kind of understand each other, because a man of your importance should be heard and I want to give you that opportunity. Let me give you some free legal advice, if I may be permitted. A subpoena is merely a legal document notifying a person that his presence will be required for testimony.

Mr. MAY. I understand that.

Congressman DOMENGEAUX. It is purely the medium by which the notification is made. Actually, you have received a subpoena because you have been requested to come up and testify, and we would be very happy to hear your testimony.

Mr. MAY. Well, I am rather enjoying myself here on the testimony that is being presented. I would like to hear some more.

Congressman DOMENGEAUX. Mr. May, you have made some very serious charges.

Mr. MAY. I can absolutely back up the charges.

Congressman DOMENGEAUX. We want to give you that opportunity, and I don't see why you are hesitating to come over and testify.

Mr. MAY. But I am not prepared at this time, I am sorry to state.

Congressman DOMENGEAUX. We have been very considerate of your feelings, and I think you have made charges that one of these mag-

azines has published, and the American public doesn't know whether they are true or not. If they are true, they should be substantiated, and if they are not true they should be refuted. You are now given that opportunity. I have given it to you before and want you to come up and testify, and I cannot understand why you hesitate to do so. You don't want to testify at this time?

Mr. MAY. Not at this time. I would like to hear a little more of the testimony.

Congressman DOMENGEAUX. When do you think you will be ready, sir?

Mr. MAY. I don't know when I can get these people into town.

Congressman DOMENGEAUX. I am interested in your testimony.

Mr. MAY. Well, I have to have these people back of my testimony.

Congressman DOMENGEAUX. Later on I may take the position that I consider, because of your attitude, that you are not worthy to be listened to, and I may not even care to listen to you later on after these opportunities are given to you now. I represent a committee of the Congress of the United States and have requested you to come up and testify, to substantiate your charges, and you hesitate and fail and refuse to come up and testify, a most reprehensible act.

Mr. MAY. I didn't expect for things to come up as fast as they did, and other people have to come in.

Congressman DOMENGEAUX. Mr. May, you have been posted at every opportunity of every move I have made since I have been in Milwaukee. I sent you a telegram asking you to contact me, and spoke to you two nights ago in my hotel, and I told you when we would be ready to have you testify. I told you we would start Friday, today. It is logical, because of these circumstances, that you should really be the first witness, and still you hesitate.

If course, if you did a thing like this in Louisiana—I can't see why, in all fairness both to the staff and the hospital, the doctors and the nurses of the hospital, and to the patients in the hospital, why this man refuses to testify. I can't understand it.

A PATIENT. If he has made charges, let him get up on the platform and substantiate it, or retract them. If he refuses to show the base for these charges, the charges should be refuted. If he has criticisms of the doctors, nurses, and patients—we are patients here—we would just as soon hear.

JAMES H. ZIEGLER, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you kindly give us your name, sir?—A. My name is James H. Ziegler, Dayton, Ohio. I am one of the old relics around here, too, hospitalized for 9 years, and 7 of them here. I have been out of the hospital once in that time, out of the building once in 5 years.

All this bosh is just so much fog and no wind. We want to get things right. All you need to do when you go back to Washington is to tell them down here is an individual hospital, and what takes place here the people should be held responsible.

I came here a total paralytic in the year 1938; lay 2 years in ward 20—16 months to be exact. I have fought tooth and nail to have something done for me, and if one of these doctors hadn't defended



me I would still be a paralytic or maybe dead. Finally, this machine got to moving after I almost tore the building down, and they called in an outside specialist who looked my case over. He diagnosed it as tuberculosis of the spine. He said, of course, he could fix me. They moved me within a month over on ward 14, and it took them over 3 weeks after I was over there to even take me up to operate, call this man in to operate.

Q. You feel that the treatment, or putting the thing in motion, is much too slow?—A. In the past these doctors here have been too cautious, overcautions.

Q. Overcautious?—A. The younger man loses his own initiative. He has to work from a book in Washington. When I got over in ward 14, through this operation—all these doctors said it was a 10,000-to-1 shot—I walked up them steps today. Six years ago—after the operation was over they didn't advise me how I was going to get on my feet. Told me, "There is a walker," and showed me how to help me get in it a couple of times, showed me how to back a wheel chair against the wall. I had to pull myself into that thing, and fight my way in the harness.

Q. What more could have been done for you?—A. Took an interest. If I had been like some of these other people that were easily discouraged, I wouldn't be walking today.

Q. You feel that there should be a closer relation generally between the doctor and the patient?—A. Yes; there should be.

Q. Where consideration in the discussion of a patient's case should—A. I was transferred down to the Annex. I stayed down there for 5 months. Finally, I got so I could walk on canes, and then I went home. I developed a cough. I tried to get in the hospital, in our new hospital at Merzfield, just outside of Cleveland, and they wouldn't take me on account of having a t. b. record, so I was forced to come back here. When I say here—cough, cough, cough, years after year, nothing done. The doctors have all been too willing to associate every ailment a man has with his t. b. See what I mean? They had that as a warning, when that was coming on, what was happening. They never took the necessary steps to find out until 2 months ago they give me what they call a lipiodol test. That didn't come out so good. Finally bronchoscoped me and found out what was wrong. Now I am under penicillin, and tomorrow I am going to start something new.

Q. Did the penicillin do you any good?—A. A great relief, sure, but it is no cure, I don't think. The idea is if they had done something 3 or 4 years ago I probably would never have developed this that I have in my side, violent coughing day after day and night after night.

Q. Red tape?—A. Have the responsibility there where we can put our finger on it.

Q. You have something there; too much red tape.—A. They have as competent medical men here as anywhere, if they pay them the proper salary and give them the responsibility. We don't need to be doctored with a blueprint. How does the man in Washington know what is the matter? Even if he does have the record, he doesn't see me personally; he doesn't know my condition. I would like equality for the veterans.

Q. What type of equality?—A. Down there in Washington, about one man being paid \$8 out of his pension, and another man \$20, and

another \$50, and another man \$150. We all served under the same flag, and we are all entitled to the same treatment, should we not?

Q. You mean a non-service-connected man should get the same base pay?—A. As the service-connected.

Q. You mean a service-connected man should, for a similar injury, not have a larger compensation than a non-service-connected man?—

A. I mean a married or single man, nonservice, should be paid alike.

Q. I may tell you there is a bill now before our committee where the single man who goes into the hospital will not be penalized. He will continue to get the same compensation that he did before he went in, the same as if he were a married man. I think that bill will pass. I don't know.—A. The last time the gentlemen raised their pensions there, the single man didn't get a single dime. The first time we got a \$2 raise. The second time we didn't get a dime.

Q. Are you single?—A. Single now; yes.

Q. Well, I think you have got something there. Have you got anything else on your mind?—A. No; I guess not.

(Witness excused.)

Congressman DOMENGEAUX. It is about 4 o'clock. We will adjourn until tomorrow morning at 10 o'clock.

(Whereupon adjournment was taken until 10 a. m., Saturday, July 21, 1945.)

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WOOD, WIS., *July 21, 1945.*

#### SATURDAY MORNING SESSION

(The hearing convened at 10 a. m., Congressman Domengeaux presiding.)

Congressman DOMENGEAUX. Will the meeting please come to order?

We have with us this morning Congressman Wasielewski, who came in from Washington this morning. I am glad to have him be here with me today. Although he is not a member of the Veterans' Committee, he has shown a very marked interest in the welfare of the veteran, and I think we are fortunate in having him with us today.

Is there anyone this morning who wants to come up and testify, as we did yesterday? We would be very happy to have him come up.

MIKE BACICH, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, please, sir?—A. My name is Mike Bacich.

Q. Where are you from, sir?—A. Eagle River, Wis.

Q. Do you care to testify and tell us what you think about this institution, the way they have treated you?—A. I can say a lot of good and I can say a little bad, and I can leave part of it out.

Q. Let's hear a little of the bad first.—A. I came here 3½ years ago, one of the first young fellows that came into this place.

Q. Are you a veteran of this war?—A. I wouldn't put it that way, because I didn't get across. Most of the boys all disappeared and I am the only one that is left out of the whole gang. There have been a lot of changes in this place since I first came in January 1942. I had a pretty good record until I went out last summer.

Q. A. W. O. L.?—A. No; a. m. a. It was through the authorization of the out-patient department, and they had a private doctor take care of me up north.

Q. After you left against medical advice?—A. Yes. They authorized it before I left. Things got along good, until I had to come back. I mean I came back for my own good.

Q. You felt that you could get much better care in these veterans hospitals than you could on the outside?—A. I had to travel a hundred miles to a doctor, and I am nearing the completion stage, I believe, of my treatments, and that is why I came back to complete it here instead of completing it on the outside. I want a doctor handy where he can tell me at all times what has to be done. From the first time I came here up to now, I will admit that the food has improved an awful lot. I can tell by my weight. I can still put on a little weight. When I came in here I weighed about 92 pounds and went down to approximately 75. Now I weigh around 133. I still can use another 20 pounds if I can find it.

Q. You find the food has improved in quality or quantity, or both?—A. In both. The meals—I mean before, I would say we had an average of one fair meal a day. Now it has gone so the meals are much better. If I complain too much about it—I can't complain because—

Q. Has the food improved in the last 3 or 4 days since this congressional investigation started?—A. That seems to be the talk all the time, but I don't know. The food is good at times, and bad at times.

Q. That is true in anybody's home, isn't it?—A. That is true.

Q. The Congressman, I think, will agree with me that we who have been there for the last 5 years—we went there together—can live and eat in the House restaurant, and I think after having eaten there for some 4 years, even though the food is good, we kind of get disgusted with it. Isn't that rather a characteristic of human nature, that you get tired of anything if you get it enough?—A. That is true. I believe this food is steam-cooked, and while nothing compared to home-cooked food, I will agree on that. I would rather have home-cooked food any day than steam-cooked because there is more of a taste to it. All in all, it has been pretty good.

There is one thing especially about the canteen service here. It is run by private enterprise, and the prices—I do know this, that the prices are high in many things. Some things are normal, but in comparison with downtown prices of Milwaukee—but the canteen here handles a little bit of everything and not much of anything, and by that I mean you can go there and buy the barest of necessities which you have to have to get along with, but we have to send out an attendant, or some visitor—they go downtown and buy the brands or the things we want. Here they carry a certain select stock.

Q. Do you think the canteen could be more competently operated by the management of the hospital, or by private enterprise?—A. I think it is all much of a private enterprise up until now, and I think if they had a change it certainly couldn't be any worse; in fact, it might be a little bit better. I don't know whether they have authorities for some things or not, but if they do I don't see why they can't get it. There is a lot of things we can't buy at the canteen here, and we have to tear all over downtown in Milwaukee. We send the Gray Ladies, or someone else, to buy all these things for us.



Q. Your canteens are in the same category as any other business establishment; you have no priority?

Major FROEMMING. We have little priority. We have assisted them in every way possible in getting merchandise, but it is very difficult. The item of white shirts is very much in demand by our attendants. It is a very difficult item to buy anywhere in Milwaukee.

Congressman DOMENGEAUX. Anywhere in the country.

Major FROEMMING. That is right.

Congressman DOMENGEAUX. The prices prevailing in the canteen must be approved by the management?

Major FROEMMING. We have a committee that rules on all prices of articles sold in the canteen, and the rule is they must compare favorably with business houses in the immediate vicinity of the facility, except, of course, cut-price drug houses; we can't expect them to have many leaders, like low-price cigarettes, or things of that sort. The prices are all permitted by management.

Congressman DOMENGEAUX. Governed by the price ceilings?

Major FROEMMING. Governed by the prices that prevail in the community.

The WITNESS. The most of the employees had their pension cut and get about \$20 a month. The boys spend quite a bit. If they had a place where there was a nonprofit organization, and what low profits there were were turned back into the canteen, or some form of recreation where the money would be in a continuous cycle, that would be much better than the way it is run now.

By Congressman DOMENGEAUX:

Q. You may be correct in your views, but I think and many people think that you would have a much worse situation if your canteens were operated by your administration proper. You would have the red tape and the routine, and they would have to get an order from Washington before they could buy a carton of cigarettes, and I think you would have a worse situation. That is a matter that I am sure suffers as a result of the war. Goods are scarce and you just can't get the things that you could get before.

Are you charged up here for cashing your checks?—A. Yes; we are.

Q. How much?—A. Ten cents.

Q. Do you know whether the person who cashes your check must pay a similar charge to the bank?—A. No; I don't. Sometimes I have taken my check in other places and they have charged, and some places they don't charge. I don't understand it.

Congressman DOMENGEAUX. Can you give us any information on that, sir?

Major FROEMMING. The concessionaire or, in fact, anyone who goes to the bank to cash a check or convert a check into cash must pay a substantial fee for that service. In turn, the concessionaire passes it on to the person who cashes the check.

Congressman DOMENGEAUX. No profit?

Major FROEMMING. We have investigated a time or two, and it seems to be fair and reasonable.

Congressman DOMENGEAUX. Couldn't some arrangement be worked out with the bank where these checks could be cashed without charge to the veterans?

Major FROEMMING. We have recently completed a plan by which our finance officer will carry considerable sums of money—sums very much in excess of what he carries now—and he will make the round of the wards and render finance service to the veterans. Also, the pots office is going to establish a branch at this canteen right here in this building, and they will be able to transact postal business for our patients.

Congressman DOMENGEAUX. And the cashing of these checks at the same time?

Major FROEMMING. That is right. They can send home certain parts of the money or buy postal-savings certificates, or do any other post-office work. That should be in effect within the next 2 or 3 weeks.

The WITNESS. The things we do buy at the canteen—if you buy toothpaste you probably get one or two brands. They have more brands than that downtown. It is just the idea that we have to take what they have, and that is all. Another thing, this business—we will drop the canteen for now.

By Congressman DOMENGEAUX:

Q. All right, sir. Did you ever see any cockroaches and other things in the canteen?—A. In the canteen? Is that the only place?

Q. Where else have you seen them?—A. I saw them walking along the floors.

Q. Where?—A. I can't say that recently, because I haven't been looking at the floors recently. When I did first come in here I used to take a look at those little animals walking down the hall. I don't say that this place is numerous with them. I have seen them in the Army mess halls. I don't know, but occasionally now and then you are bound to find one some place. We found them in the Army, and I suppose you find them any place where great quantities of food is served. As far as finding them to make me lose my appetite, and things like that—the only thing that makes me lose my appetite is to see people carried out here feet first.

Q. That is depressing, I will admit.—A. We had visiting hours one night a week and every afternoon in the week. I think the boys will agree with me that most of their visitors work every day, and the only time they come out is perhaps on a week night or on a Sunday afternoon. Some on the night shift, the only time they can come up is on Sunday afternoon and, if you are lucky, they have them every afternoon.

The movies were on a Tuesday and Friday night, and if they had a visitor some guy paged you down here, "So-and-so looking for somebody" during the movies. Because of the war they decided that all these visitors would be—well, they would congest the halls, and they decided to cut the visiting nights to Wednesday night only. Now, that the war is over, I was wondering whether or not they are going to go back to the same schedule.

Q. What has the war got to do with visiting hours? It is very convenient to blame the war for all our troubles.—A. That is the general attitude we had for everything.

Q. It is very convenient sometimes.—A. It is a good excuse. I don't know what the reason was for cutting it down at that time.

Q. You have got to have rules and regulations, and you have to have someone to make them. That is a question of administrative management, and you have to respect their discretion in the matter. You are

fair enough to understand in an institution of this kind it has got to have rules and regulations, and discipline must be maintained. Whether that circumstance that you relate is unfair or unreasonable, I just can't quite know. It is a matter of discretion on the part of the management. I mean, if you were a manager, how would you handle that particular situation?—A. Well, I am not the manager.

Q. I mean if you were, how would you handle that particular situation?—A. I mean just because it is only 1 night a week I would try to see that they had at least 2 nights a week.

Q. Then some of the boys would be dissatisfied because there were only 2, and then we should maybe have 4 nights a week.—A. No. I don't know. I don't know what the visiting nights were prior to 1940, or anything like that, but I do know the first time in 1942 it was 2 nights a week, and if they couldn't come on one night they came on the other night.

Congressman DOMENGEAUX. Major, would you give a general explanation? There is no criticism on my part about a thing like that.

Major FROEMING. I would like to ask Colonel Mullins to explain that.

Congressman DOMENGEAUX. The general thought that motivated these particular regulations with reference to visiting. I have heard some complaint among some of the boys. They thought they should have more. I have no criticism on that score, but I would like to know the general thought that motivated that particular ruling.

Major FROEMING. Inasmuch as it is in the Medical Department, I think Colonel Mullins is best able to answer that.

Lieutenant Colonel MULLINS. The visiting hours have not been changed since I was assigned to duty at Wood, Wis. Some of our hospitals have no special visiting in the evening. Some of our general hospitals utilize every evening for visiting purposes. In all of our tuberculosis units visiting in the evening is reduced to the minimum. The men can have their visitors every day, especially in the afternoon after regular rest hours, and it is our policy here at this place, where a patient's home is quite some distance and his people have only rare opportunities to visit him, that they are allowed special privileges to visit when they come.

Congressman DOMENGEAUX. Thank you, sir.

By Congressman DOMENGEAUX:

Q. Have you got anything else on your chest?—A. Consumption. Outside of that, I am healthy.

Q. I am glad to see you getting that off, too, and I am glad for you. You are evidently doing all right.—A. Yes. The reason why I left at that time, the regulation stated at that time you couldn't be discharged without taking pneumothorax. Since then they have sort of changed their mind. I understood perhaps I would have to take 2 or 3 years, and I couldn't stand the thought of sticking around this place another 2 or 3 years as long as I was getting along pretty good. Now it is a little bit different, and is much better.

Q. Would you care to explain the general policy that is employed by the doctors in tuberculosis cases in discussing with the patients the characteristics of their disease and the necessity to be patient, and to understand that if they expect to get well it will take a long period of time, and they have just got to make up their mind to take this bed



rest and the other types of treatment? Is there enough of that that prevails in this hospital, in your opinion?—A. I would say it all depends upon the doctor. I mean we do have on our floor. We have a very good doctor. In fact, I have had about seven or eight different doctors already, and I have had some at St. Mary's Hospital in Wausau. They are supposed to be pretty good. The doctor we had is, in my opinion, a wonderful person; I mean he is pretty conscientious. He will take the patients into the rooms and discuss the case over with them. He will meet you half way. If you will listen to his advice and carry out his instructions, I think most of the boys fare much better, because so many things—a big percentage of this falls on the doctor's shoulder. Since I have been at this quite awhile, I find the biggest load is to be carried by the patients themselves, and cooperation from the nurses and doctors with the patient is the only thing that will get them well. The mental attitude is about the thing that does the cure. I have seen some people come in here supposedly saying—I must say in a certain length of time they have gone a little batty. Sometimes I wonder myself. I find if you let your mind—I mean in the cure, as they state, you are supposed to put your body at rest and try to get well. But then it doesn't mean you have to put your mind at rest. If you do, your mind will rot and decay. I mean it has happened and I have seen it. I have seen them lay and look at four walls and the ceiling day after day, eat three meals a day, get a glass of cathartic, and that is all. That isn't all; I mean they should change their routine every day and do something a little bit different. By doing that I found it worked out the best.

Just a while ago Colonel Mullins told me they were bringing in something along in correspondence work for the boys, and I have wondered and I have inquired all over, and nobody seems to know anything about it. Inasmuch as my education is all set, I can't go to school until I get well. That doesn't prevent me from wanting to study with the O. K. of the ward surgeon. Since I can't get my books here, I have nobody to turn to. In fact, many of the boys wanting to take up correspondence work have to do it on their own shoulders.

Q. The GI bill has recently been amended where correspondence schools have been placed in the same category as colleges, where a veteran will be able to take his correspondence course at the expense of the Government.—A. Does that cut in on his further education after he gets out again?

Q. No, it doesn't; but he does not get the \$50 per month provision, as does one who attends school regularly.—A. In other words, when he takes his correspondence course he can enter college and continue the full amount?

Q. I am not so sure on that score. You should look into that. The correspondence courses are now available, and in your situation I think it would work out very nicely. You don't want to jeopardize the period of time that you may be able to attend school hereafter?—A. That is right.

Q. You should look into that angle, and I think you should go to school, too, because you impress me as a very fine, intelligent young man.—A. I don't know. During the time I have spent here I have done a lot of reading. Most of it has been fiction. When you read something that is heavy and serious you have to think a lot, and I don't want to do any thinking. [Laughter.] Thinking sometimes

is very detrimental to an individual. It is so much easier to just go along and not think. I graduated in 1940 from school, and sometimes I think I graduated about 20 years ago, the way it seems. I don't know. I can do simple arithmetic and read and write, and that is about all I feel like doing.

Q. A pretty good talker, too.—A. The gift of gab is in the family. All in all, I mean I want to try to get well here, and I am going to stay here. I find most of the boys, especially on the TB wards, do waste a lot of time. They wander around aimlessly and listen to the radio and read and write. If all of them would take something that would be more interesting or beneficial to them when they get out of here, instead of wasting all their time in a hospital trying to get well, they would be well and at the same time would further their education.

Q. Does the management of this hospital devote sufficient time to encouraging these tuberculous patients, providing for them the necessary means for intellectual development while they are on their backs taking this rest cure? Is much effort made in that direction that you can see? I think it is very desirable.—A. You do? In some respects, yes; but I mean in what lines do you say it is desirable? They have the occupational therapy.

Q. What else do they provide?—A. A good fast game of checkers. That is what my doctor told me. He said, "That is the fastest thing you can do."

Q. Well, are you supplied with books? Does the library service extend to these wards?—A. The library service extends to the wards. It is fiction and literature to a certain extent, but I mean they have a photography book and perhaps a cartoonist book and one or two things like that. If you want to take up cartooning, you have to send out and get somebody to buy all the equipment you need. Here they don't handle all those things. In other words, out of the library—while they have a well-stocked library, they have all the books you need and papers, but that is just everyday reading material.

Congressman DOMENGEAUX. Would you gentlemen care to explain the general policy and system that prevails with reference to this occupational work for the patients, that which is provided and that which is available?

Lieutenant Colonel MULLINS. At the present time we have an academic commercial aide assigned for the purpose of starting the studies for the patients in the tuberculosis unit. We have been unable to get anyone that was qualified for that work until now. Consequently, the work over there, the training, commercial or academic, or art, or whatever it is, has been on the patient's own, for the simple reason we have not been able to give them any assistance on that and we will not until the first of next month. Then this will be organized over there. Any studies that they wish we will be able to take care of.

Congressman DOMENGEAUX. Why has the Veterans' Administration waited some 25 years to put such a program into practice? Today, I can understand why you can't get these qualified men, but it looks like all of these reforms—don't misunderstand me, Colonel, this is no reflection upon you; I am speaking of the general policy, because I think you have done a magnificent job with that which you have had—but it looks like the Veterans' Administration is now, after some 25 years, trying to put all of these reforms in, and they blame the war for their



inability to do it. All of these things are now being put into effect. For instance, the chaplain service is now being put into effect.

Lieutenant Colonel MULLINS. That is right.

Congressman DOMENGEAUX. The occupational therapies are now being put into effect, and all of these various programs, which I think should have been established many, many years ago, are now being put into effect.

Thank you, sir.

By Congressman DOMENGEAUX:

Q. Keep on, partner.—A. I am taking too much time. Any of the minor arguments I had I would straighten out with the ward surgeon. If not, I go up one step over that.

Q. You have been here 3 years. Has anyone been intimidating, threatening to put you in the nut house?—A. The patients. [Laughter.]

Q. The patients. But the doctors, have they been doing it?—A. One doctor told me I was doing a wonderful job. As long as I was slap-happy and went around telling a lot of big lies and stories it is a boost for the morale of these patients; anything to make them laugh, and happy and contented, that is the thing to do, not to discourage them and cause discontentment among the boys.

Q. You certainly shouldn't take life too seriously.—A. In a place like this you can make it a hell if you want to, but you can make it a nice place if you try. The only thing to do is to make the best of it and let it go at that.

Congressman DOMENGEAUX. I think your philosophy is excellent. Thank you very much.

(Witness excused.)

STEPHEN MATOVICH, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name?—A. My name is Stephen Matovich.

Q. Where are you from, sir?—A. I am from Milwaukee.

Q. We are happy to have you, and tell us what you want.—A. I have been coming, off and on, to this institution since 1936, and the nurses and everything else was perfectly O. K. with me. The food is excellent, and the place is good. But there were some instances here a couple of years ago which I felt that was kind of delaying me too much in my case.

Now I like to speak in reference to these men, and myself, in the same condition as I am. We have a family on the outside to take care of, and if we are delayed in here 3, 4 months the things go wrong on the outside. I have trouble if I go and tell you that my home is busted, and everything through this. Two years ago when I was here I came here after I was X-rayed downtown at the Milwaukee Medical Center, and they told me I had ulcer in the duodenum. Then they sent me to the West Side Hospital, and I was there 2 nights and 1 day, and there was no orderly there. The nurse wasn't fit to be a nurse, in my opinion.

Q. Where are you speaking of?—A. I am speaking about the West Side Hospital. I went to a private institution. Then I seen if they would operate on me I wouldn't have no help.



Q. How do you compare these private institutions?—A. I compare this one much better.

Q. It should be. We spend about twice as much money per patient. When I say "we," I speak of the American taxpayer.—A. I was anxious to get out as soon as I could. I had a pretty fair job at the Kempsmith Milling Machine Co. I wanted to support my family, and I just bought a home 4 years ago. It happened to be that I was delayed so long.

Q. You mean after you got at Wood?—A. After I got at Wood. I was in ward 5.

Q. You had an ulcerated condition, a stomach condition?—A. Yes, sir. The way it was, Dr. Rhea was the doctor at that time in ward 5. He decided that I should have—what do they call that, now, when they put a hose in the stomach, and they have a gallon on the top and another one on bottom?

Q. Gastroanalysis?—A. I had to have that every night from 9 o'clock to 9:30. They put the hose in my stomach at quarter after 4, because he goes home at 4:30. I had to sit there or lay in bed by 9 o'clock; the nurse opens the clamp so it would work from 9 to 9:30.

Q. How long did they keep that up?—A. For 3 nights, from 4 to 9 I had to sit there for nothing. If it worked it would be all right. I asked Dr. Rhea if I could put that in myself at quarter to 9, so I wouldn't have to be tied down to that jug for 5 hours. He thought I wouldn't do it. Sometimes I had to eat my supper over that. That was 1943. Finally, one night I got so sick I told nurse—a fellow by the name of Roy is orderly there; I told him, "I am getting sick. I am going to vomit." At quarter to 9 I vomited the hose out, and everything all over the floor. I felt ashamed. I couldn't help it.

Q. It wasn't your fault. I would have done the same thing.—A. I stayed there over 2 months, I think. Finally, they transferred me to ward 15, after they decided—after I was through with stomach—whatever you call it—ulcer diet. Then Dr. Jones was here at this time. He was above Rhea. He examined me and he decided I had gall-bladder trouble, see. I had to be on a gall-bladder diet for a couple of weeks. Finally, they sent me over to 15, when Dr. Neacy went on vacation. He wanted Dr. Neacy to work on me, and he wasn't there.

Q. That is the doctor that was putting that tube in your nose all the time?—A. No; it is a doctor in ward 15. He was surgeon. Then, I was sitting in solarium one day and the window cleaner came over and he was cleaning windows. A bunch of us was sitting in there. I didn't think I was going to catch a cold, but I caught a cold. I was treated for a cold, and I asked Dr. Goodman at that time to let me go home a couple of days. I was nervous. I was vomiting all the time. He said, "You want to go home," kind of rough, put his hand on my shoulders. I said, "I want to go home for a couple of days." So he told Dr. Slaybaugh to give me a pass. When they started to write it they said the only kind of pass I could get is a. m. a., that is, against medical advice. I was kind of upset. I said, "Well, sure," and I took it. So I went home. When I came home I couldn't do without any kind of medical attention so I went to see Mr. Gulczynski.

Q. Who is he?—A. Al Gulczynski. He was here yesterday. He is head of the Soldier's Relief Commission. He helped me to get in

county hospital, and when I got there I was there 3 weeks before they operated on me. When I was operated there, the third day when I got out of hospital my left foot started to swell, and then I was compelled to come here. They brought me here in the ambulance.

Q. An emergency case at that time?—A. Yes, sir.

Q. Don't you think this doctor was perfectly correct and justified in not wanting you to leave the hospital and that you should continue your treatment?—A. I was just going to go 2 days. My family was upset at home, see.

Q. I know. That is a matter of medical discretion.—A. Sure. I know how things were going at home. So when I went there I came back here, and I was here 2 weeks and then I went out. I was treated for emergency. I went to work. I was home a couple of months before I went to work. I went to work on August 1 and I worked until January 1944. I came here in 1944 in January. I was in ward 10—that is receiving ward—16 days. After 8 days my stomach begin to feel better and my wife came up here to see me, and she wanted to know how I was getting along. So the custom is that the doctor doesn't tell the patient. I told her, "You go and talk to the doctor." She went over there and he told her that I will never be a normal man again, and that there is nothing wrong; I could go home. So they discharged me 2, 3 days later and I went back to work. On April 7, 1944, I came back again worse than ever, and I didn't strain myself at work because I had an easy job.

Q. With a stomach condition again?—A. Yes, sir. Then I came here, and 3 weeks after I was in here I got so bad that I couldn't get out of the bed any more. If I get up half an hour that is the limit. I had take hypos and pain pills. I have been taking hypos for 8 months, until last November when Dr. Rhea went on vacation I asked for transfer, and I got transferred into ward 6 and Dr. Sagi took care of me. At the end of second week I didn't have to have hypos any more, and then I was treated by the doctor about 6 weeks, and Dr. Sagi got sick and he went to the hospital. That is a fact. And Dr. Coon was there for a little while and he got transferred, and he took Sagi's place in out-patient department. Dr. Meyer came in.

During this time my wife died. Then I wasn't well enough as yet, but the conditions at home made me so I should get out and take care of those four kids. They are home alone now with nobody to take care of them. They take care of themselves. So I was out there until I couldn't stand it. I can't walk further than two blocks without stopping. My legs are sore. They tell me now I have Buerger's disease. I have a sore toe. The bone healed for 7 weeks already. I am here now since 18th last month. I am in a condition like this, and I like to express my opinion that if it is possible that these men that have homes, families, that somehow some arrangement could be made, if it is possible, that they could be fixed up so they could go back to their homes before their homes are broken up.

Q. Well, that is a very serious situation. The law is today that provisions are made under certain circumstances where a man is permanently and totally disabled, and there is no good that he can derive while in the hospital, they would pay him an additional \$50. These matters are decided on individual cases and individual merits. Your problem is an administrative one, and it is very unfortunate. I

don't know what can be done to solve your problem. Have you seen these service officers—A. I spoke with contact man yesterday.

Q. And discussed these things with them?—A. Nothing can be done except through State organization, according to what he told me.

Q. Are you a service-connected veteran?—A. No, sir. I felt this way: I came from Denver, Colo., and, as you know, in Colorado we didn't get no State bonus, or nothing. We didn't ask for anything. We were too proud to ask for anything so long as we were able to make our living. I lived in West Allis from 1921, about November, until 1935 in December, and I know when they put this Foundation here, and I didn't know that I could come in this institution until 1935 in December. I didn't even inquire till my stomach started to hurt and I met fellows down at the county dispensary down here, because I had more faith in those doctors than some of those, for instance, in Wisconsin Medical Institute. I went down there about 6 weeks ago. He charged me \$5 for nothing—sure. Then I went to Dr. Harvey. He wants to give me shots in the arm, \$8 a shot, see. That is—I didn't trust him, you know. I couldn't take it that way. I have more faith in these doctors.

Q. Generally, you feel that you have been treated well and you would much rather be in these hospitals than private hospitals?—A. Certainly. I was in the county hospital 5 weeks, and in those 5 weeks you can only get a newspaper; you can't even buy matches in the county hospital. Visitors are allowed every other day and every other night, not on Sunday at all, see. Insofar as visiting is concerned, they are not strict here. I notice that. Even sometimes the kids can come out there on the lawn and speak to me, and they didn't chase them off yet. So that part is all right. Nurses are good. Food is excellent—everything, but the things that you have summed up in an article that I read—I listened to you in the solarium over there when you spoke in ward 4, and I think you have got things analyzed pretty close.

Congressman DOMENGEAUX. I wish you were in my district. You could vote for me. [Laughter.]

(Witness excused.)

Congressman DOMENGEAUX. Anyone else, please?

CHAUNCEY GUTHRIE, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Good morning, sir. What is your name?—A. Chauncey Guthrie.

Q. Where are you from?—A. Waukesha, Wis.

Q. Let's hear your story.—A. I was from the veterans' hospital about a year ago. I came in June 1944, and spent about 11 weeks at that time, and then I came again in February 1945, and spent about 3 weeks at that time. I came the first time for a hernia operation, and then I had varicose vein trouble and so they took care of the varicose veins instead of the hernia. When I got on my feet and got the dressing off, they wanted to get me another truss to wear. They stalled time there, and I think I could have been home 3 or 4 weeks sooner.



Q. You thought they were a little slow?—A. A little slow in getting around the discharge. During the winter I developed a slight cough, and they couldn't operate then. Aside from that, there isn't very much.

Q. Generally, what is your estimation of this hospital in the treatment?—A. I think their weak point is the time they spend before they do much of anything. Maybe there is a week or so of lost time. There is a little red tape when it isn't an emergency ward.

Q. A little too much time lost?—A. Breaks down the morale of the patient. I think if they would take a little less time that way, the fellows would go home better satisfied. The fellows kind of kill time around there.

By Congressman WASIELEWSKI:

Q. Is it possible they are overcautious?—A. When they get here they are too far gone for good measure. Another little side line on the car is on the entertainment subject. Here the radio headphones pick up one program that they give you, and in my opinion they lean a little heavy toward the Columbia broadcast chain.

Q. Do you think they are being paid off by the Columbia people?—A. I don't know anything about that. I know the programs go a little stronger: baseball games, prize fights, and news reports. I go a little more for music programs, myself. I think in time—it can't be done for a year or two, but in future time they could probably have selection of three stations with the chain hook-ups that you have got that would cover practically all the programs. Until then maybe they could give a little more time to radio programs and a little more selection. Let us have a little pool of these programs they wanted.

Q. I think that is very desirable.—A. Sometimes you get headphone sets that don't work at all and it just spoils the program, so that there isn't much enlightening to a program that is broken off. You pick up a phone in the middle of the program and it don't mean anything. If you knew ahead of time what the program was going to be, you could get the station.

Q. The radio is a source of much consolation?—A. For a fellow lying in bed, it is. The time I spent playing cards when I could half sit up—

Q. What do you play, solitaire?—A. About six different ways. I could spend an hour showing you all the different ways.

Congressman DOMENGEAUX. Thank you, sir.

(Witness excused.)

EDWIN B. BURSHEK, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Good morning, sir. What is your name, please?—A. Edwin B. Burshek.

Q. Where are you from?—A. Westfield, Wis. I had a rather hard time getting here this time. I was in here in 1935 for examination, and I got that, and then I was living at a farm that time. Cold weather came. The corn began to freeze and I left against doctor's advice. I didn't try to get back. I didn't make any application for pension, or anything of the kind; just for an examination. I got that

and a couple of years later I asked for a peddler's license, which I also got.

Q. Peddler's license from your State authorities?—A. I got the letter from here, from Wood, and then I got it from State authority. So I didn't ask for pension. I figured as long as I could make my own living I didn't want any.

I was injured a year ago last December, and operated on a year ago last February. The operation wasn't successful. It was an insurance case, and I was operated on in February and I couldn't go to work. I tried to go to work, but I tried again in August, worked a few days, and then I would have to lay off a few days to get any rest. I went to the doctor down here and I told him I would like to get in here. He says, "I can't make you an emergency case because you aren't sick enough to die or you aren't good enough to die."

Q. He wasn't quite sure which?—A. He didn't know which.

Q. You didn't clarify him on the subject?—A. Why, no. And along in January I quit work entirely, and then I told him—bills was piling up; I said, "I have got to get that knee fixed or I will have to see where I get aid." So he finally made arrangements. I got in here July 5, and I had my blood test and my X-ray of the knee, and then for a couple of days I didn't hear anything. Then I got a letter from the service officer stating that he had had a letter from Dr. Froemming that I had executed the wrong form. Thanks to Dr. Froemming for not losing any time in notifying me. They executed the right form and my case has been going pretty nicely I think.

Q. You have been in the hospital since when, the last time?—A. July 5.

Q. Of this year?—A. Yes, sir. It is the first time I have been in since 1935. I will say, as far as help and the treatments you get here, it is much superior to what I got a year ago in Minnesota.

Q. You mean in a private hospital?—A. In private hospital; yes, sir. I can't see how some of these nurses can still come back to a fellow who musses up his bed; threw it on the floor.

Q. He messed up his bed, got mad and threw it on the floor?—A. The nurse said, "You didn't make your bed." I told them I wasn't going to make a bed, and I am not going to. She made the bed and said nothing. A little later on this patient—the nurses were around three times to give him his medicine. He wasn't there. Night came, he was sick, called for the nurse; he called for the doctor. He groaned and hollered part of the night. When he went to sleep, he talked in his sleep. But the nurses couldn't find him the next day for medicine, and he wasn't there for meals—some of them, breakfast. He didn't go down for breakfast one morning, and said, "It isn't fit to eat." I imagine it doesn't compare with a lucious soup, chili, and stuff like that, that they get in these cheap taverns, but I find it pretty good. Of course, I do find it can be terrible. I found that out. The first couple of days I was excited and didn't eat much. After I was here a few days I got very hungry. I went down and got a nice helping. I was still hungry. The food tasted good, and I went back and told them how good the food was and I would like more, and they gave me another generous helping. When I was half through I was filled up. I humped up and down a few times and made room for the other. That night I found what a fellow gets when he makes a pig of himself.

When I was injured a year ago last December, I was supposed to have been operated on by a doctor in Madison. He took sick, so they took me to a doctor in Minnesota—Minneapolis. I had my X-ray pictures taken of my knee before I was operated on. The operation wasn't successful. As a matter of fact, it was worse. So I went to the Industrial Commission and they told me I would have to get an examination, and they advised me to go to the X-ray laboratories in Madison for the examination. Then they sent me to a doctor, and these X-ray plates that were taken after the operation and the ones that were taken before showed the same disorder of the knee. Now, I had X-ray plates—I had pictures taken here in 1935, and found the same condition. I would like to have had those plates compared, because it would help us to adjust our claim with the insurance company. But our doctors feel that they would not like to become involved in a matter outside the hospital. After I thought it over, putting myself in their place, I would feel the same and I don't blame them. I feel now, though, that they aren't going to fix up my knee, and I think I will be all right again to get out and take care of things.

Q. In other words, you think this is a pretty nice place?—A. I sure do.

Congressman DOMENGEAUX. Thank you, sir. (Glad to get your comments.

(Witness excused.)

FRANK O'CONNOR, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. How do you do, sir?—A. My name is O'Connor.

Q. How do you do, Mr. O'Connor. What is your first name?—

A. Frank.

Q. Where are you from?—A. I am from the Nineteenth Congressional District.

Q. Are you a veterans of this war?—A. If you want to call it that. I came here about 16 months ago. I didn't come up here as a lifetime friend of any of the staff, nor do I know this Mr. — that wrote this article — May, and I haven't read the article. Yesterday, most of the patients had the feeling there was an organized whitewash to keep the Congressman from knowing the real truth about what was going on here. I have no personal complaint of any serious nature, but if the Congressman wants to know the full truth of what we have seen around here in a year and a half I am willing to help you out.

Q. I am very anxious to get the facts. I hope, though, that you restrict yourself to things that you have seen and that you know of your personal knowledge.—A. There is two or three things that has a bearing on this. Some have mentioned it. One is the problem of getting outside consultation or help when a patient does not have faith in the doctor assigned to his ward. We would like Congress to investigate the possibility of fixed fees for such consultations for help.

Q. Isn't there a policy where specialists and consultants are employed throughout the country in those localities near where the veterans' hospitals are situated?—A. As far as we know; there has been nothing of that type done here yet, even though some patients have spoken of the fact.



Q. Yesterday there was a young man who was going out just at that time for consultation for the nose and stomach.—A. That is true, but it was the first I ever heard of it. If I could use their names without their consent, I could mention patients that mentioned that to me. Everybody seems to fear—

Q. They shouldn't fear. I would rather see a policy where these hospitals could become so proficient from a medical standpoint that they would have these outstanding specialists in the hospitals proper.—A. That would be grand if you could do it.

By Congressman WASIELEWSKI:

Q. Don't they provide some of the specialists in the city of Milwaukee who are available here on a part-time basis from time to time?—A. At least as far as the patients know, many have mentioned that they have sought that, and had been put in a position that it was impossible for them to even see a doctor unless they left a. m. a. Whether that is true or not, I don't know, because I didn't try.

The second thing that has an effect here in causing these a. m. a.'s is the fact that you have taken the pension away from the single man for \$20 and made it \$115 for married. Dependency is not an issue because a married woman can work. A man taking the cure out here, he goes out of here virtually broke, because the \$20 doesn't pay his necessities.

By Congressman DOMENGEAUX:

Q. Congress created that differential many years ago for certain specific reasons. There were certain evils developing that should be taken care of. I may tell you that right now there is a serious movement to correct that differential, because we believe that many of these a. m. a.'s and a. w. o. l.'s are caused by the discontentment of these single veterans, particularly tuberculosis cases, who leave the hospital because of this differential. They feel they are entitled to the same payment as a married man and that their compensation should not be cut when they go into the hospital. There is argument both ways on that.—A. I have heard the arguments both ways.

Another item that might bear consideration is the long time required to effect a complete or at least an acceptable cure through the medical department on the types of cases up in the TB wards. I understand many cases run into years, and the line between when a man is able to do normal things and take a heavy job is a long, drawn-out affair, and while they are mixed with the more serious patients here and are very rigidly restricted in their freedom, it causes a lot of men to go on the outside long before they have m. h. b.

Q. What do you mean by "m. h. b."?—A. That is maximum hospital benefit, as I understand it. Outside, I understand, the board of health will hound the man until he does get such an m. h. b., which makes it very miserable, particularly for single men. He cannot work on most jobs until he obtains that. Now, the suggestion was that some wards for this type of man be provided with reasonable freedom, to get away from this prison atmosphere out toward the end of his cure, presuming when he gets the m. h. b. he is able to go to work. That is what he is staying here to get.

Q. This term "prison atmosphere" may be misleading. What do you mean?—A. The restrictions in a hospital are understood, especially with sick patients. A normal man very close to having a

certificate entitling him to go back to work is not in such a condition that he wants to comply with such a rigid discipline. As other patients have brought out, the handicap to contact with home prevails even under those circumstances.

Q. What would happen, just as an illustration, if the restrictions and rigid discipline would be removed and a patient who is well on the road to recovery would go out on a good drunk?—A. He should lose all the privileges of being in such a ward.

Q. He would, unquestionably, but I am just wondering whether it may not be wise to have certain regulations to prevent such occurrences, as far as it is humanly possible to do it.—A. At the present time the result is that the majority go a. m. a. If that is a substitute that is worth while, that is a matter of opinion.

Q. I think you have got something there, and I think much thought should be given to the reasons why these a. m. a. and a. w. o. l. cases are developing in such proportions. It is appalling the number, particularly the veterans of this war, who are leaving the hospitals before they are cured, and there must be a reason for it. We are trying to find out the reasons and prevent that, because it is way out of proportion. I agree with you. Maybe some of the causes are those that you illustrate. I think you have some very constructive thoughts there.—A. Another one: The red tape required when a man wants to leave in a hurry oftentimes causes him to go a. w. o. l., and in some patients' minds there has been the question whether he isn't better off if he goes a. w. o. l. than taking the a. m. a. Oftentimes those ideas are not justified by the facts, but that is the result of that kind of information.

To get down to thinks more pertinent to this, it has been brought out by others and will be in the future if they give enough time to all these patients that want to testify—

Q. Do you think that we have been conducting these hearings in an impartial manner?—A. So far, yes, if you don't cut them off too short. I don't mean the individual. There were so many loyal defenders of their friends yesterday, at least, that very few of the patients were able to get in.

Q. Well, the time element governs.—A. That is true. This point: There are so many patients assigned to a doctor, the excuse is given for the delays, and all this trouble that they do not have sufficient medical help. Now, the doctors themselves, if they want to be honest and if they are not afraid to say so, will tell you they are burdened with red tape.

Q. Everyone recognizes that fact. It is one of the evils.—A. They could be given a stenographer to do the paper work. The way the thing is handled here, that would take considerable work off the doctor's shoulders, making it possible for him to devote his medical knowledge to the patients' care and cutting down the delay.

Q. I think you are absolutely correct.—A. The next one, nurses; supposed to be a shortage of duly qualified registered nurses. I say that here, from my observation, there has been mismanagement in the use of skilled labor. The nurses are put at jobs like passing out linen, making beds, and many other things that have nothing to do with their medical training; that is, they are jobs that an ordinary untrained housemaid could do, leaving the nurse free to take care of the



patients. I say this because it has been used as an excuse for lack of care and the delay when these individual cases are brought up.

Q. Would student nurses and cadet nurses possibly supply that?—

A. Yes, but ordinary housemaids hired to do bed making—and the excuse of not being competent, I don't think that these people are all dishonest just because they have not medical training. They can be trusted to do certain jobs of that nature.

Q. Don't nurses do the work that you have just mentioned in private hospitals?—A. That may be true.

Q. That has been my experience.—A. If so, it is still a waste of skilled medically trained nurses that could be avoided if you wanted to avoid it, and it would leave more time for the nurses to take care of the patients, and these delays and lack of care that in some cases add up to brutality. The question is asked, have we seen any brutality around here. Directly, no, but the neglect resulting from red tape oftentimes adds up to the same thing.

Q. Will you mention one instance of neglect that you know of?—

A. Again, there are thousands of little ways in which this happens, and if you see enough patients you will find it out.

Q. I am asking you, will you kindly tell me some of these instances that you know of?—A. My memory of the exact patient it happened to, or the exact attendant, or nurse that done it, I have seen cases that a patient asked for codeine, or some other medicament that has been prescribed, and because the nurse is just too busy—it is not the nurse's fault—there would be large time delays; many other things of that nature. Nobody is to blame for it except red tape. Everybody has too much to do, and this too much to do for the trained medical help is caused by mismanagement somewhere at the top. It may not be in this hospital. That is, the rules put down from up above may make it impossible for the management here to do it.

Q. What percentage of time from your general observation—I wouldn't expect you to be too accurate on this, because it is one of opinion—do the nurses and doctors devote to this rotten paper work?—A. It is hard to tell.

Q. In relation to their whole work.—A. I would say—I have never been in a doctor's office to watch him, but I have seen him in there quite often spending a lot of time, running an hour or more—the doctors may tell you—doing that paper work. When he makes his rounds he makes notes. A stenographer could go with him, and those notes could be transcribed directly. The doctors tell you they make it out and they pass it over to the nurse, and then the nurse transfers this to some card system. I don't know whether there are two transfers or just one, but it takes the big part of a trained nurse's time transferring that. Any trained stenographer can do that work.

On the question of food, there have been very contradictory statements. The full truth hasn't been brought out yet.

Q. What is the truth?—A. The food now is excellent. It is better than in the average low-priced restaurant; not quite as good as home cooking. It is better than most I have seen.

Q. When you cook at home you cook for from two to five people, and not for 3,500 people.—A. I understand that. On the other hand, two times this week I have sent a dinner plate back because it was too dirty to eat off of. Last night it had egg all over it from dinner.



This week at my table there was a fly, that they talked so much about, in the pudding. This fly did not fly in; it was incorporated in it, with its feet stuck up.

Q. What kind of a pudding was it?—A. Some kind of a custard.

Q. It might be in the flour sacks.—A. One fly doesn't mean anything. We don't object to an occasional fly. This summer we have been fortunate there have been very few flies. Last summer it was worse. Even the mosquitoes bothered us last summer in the rooms. We asked that something be done about it, but nothing was provided to do any spraying. Whether this DDT, or whatever it is now, is available I don't know. I hope it don't happen this summer. It hasn't yet. The weather has been bad. The full truth about this food situation is that several months ago when I come here, before there was any hint of an investigation, the conditions was this: That the trays were cold; the food was poorly prepared and oftentimes dirty—

Q. When was that?—A. This is a period of at least—well, we will go back a year. Now, I don't say that of every meal, of all three that was true. The coldness was true most of the time. Even the coffee is terrible. Now, we could call for the attendant to run down and get us something special hot, but if we took what was served to us it was cold.

Q. You think the standard of the food has improved tremendously since this congressional investigation?—A. Remarkably. I will tell you just how it was improved. Just before I went off the trays, I understand there were articles in PM and Cosmo—

Q. PM and Cosmopolitan.—A. About that time, whether it was accident or not, there was a big man, I mean physically big—the whole staff here knows what his name is; I don't know what it is—sent down here to straighten it out, and he done a remarkable job. He had been here only a few days when these trays improved. I then was transferred shortly after that. He changed the whole system. I was transferred to the main dining room, to cut out the smaller ones. The food has improved and I will say it is excellent since, with a few exceptions that happen in an institution like this that you can't avoid. This man that wrote these stories, he was substantially true at the start of the investigation. Because of the investigation—that might be opinion there—this has been corrected substantially, and now the observations that the Congressman makes are true, that it is clean, it is better than average. Now, that is the full truth of the food situation.

Now, the things that I have come in contact with—a dentist, long delays. The excuse is lack of dental help. I don't know enough about that department to suggest anything down there, but I have an idea they have the same red tape. By the way, that is a cause of a. m. a.'s, because the delay is so long.

Q. You mean the dental department, or the whole?—A. Yes. I suppose for all departments the same accusation would be true. The excuse given is lack of help. If you trace it down, you will find that skilled labor has been wasted by the red tape provided by this organization. I don't blame this staff. That they all go back up above is for you to determine, because you see all phases of it. I am telling you what the patient sees down at this end.

The laundry department. They have a totally inadequate system. At least handling, you might call it, the retail end of it, the labeling, and so forth, requires pages of written work; and the tagging system. It doesn't compare with any laundry outside. Then, after this happens, we have a lot of loss of our personal belongings. There is nobody we can go to to have these made good. As a consequence, they are gone. I don't know where the leak is or who is responsible for it, whether the tagging system is bad or whether they send them outside somewhere and they are lost. Those long records waste a lot of manpower.

Now, the greenhouse. We observed here during the holidays that they produced some beautiful decorative plants in large quantities. They were brought over here to decorate the hospital. That is fine. I don't know what it cost to produce them—and I used to be in the nursery business—but it runs into a lot of dough. After they are brought over here nobody is responsible for them. I have observed time after time that a beautiful plant that costs many dollars on the outside will wilt and dry up because of lack of care. You mention it to anyone—nobody is responsible.

Q. Are the plants grown on the facility property?—A. Yes.

Q. By the employees of the facility?—A. I don't know how they handle it, but I understand that is the way it is done. No matter how you do it, it costs dough and it does not justify the expense to waste that stuff. If here is any reason to produce that stuff, it should be taken care of so we get the ultimate good out of it.

There is a definite feeling of reprisal among both the employees and the patients if they tell you about what goes on here. I won't say whether it is justified or not. That is a thing that happens everywhere and—

Q. What causes this feeling of reprisal? There must be some reason for it.—A. That is a general condition throughout industry as well, although it has died out in recent years. An employee always feels if he criticizes his employer, even in an organization like this, that eventually he will be let out. Now, I won't say that that is true. I have no cases of threats, or anything of that nature, but the employee feels that way. So it is difficult to bring out all the facts.

Q. That condition prevails, in your opinion, as it does everywhere else because of that human element and the human nature angle of it?—A. Another thing, I understand the Army—

Q. Actually, you don't know of any instances of intimidation?—A. There is plenty of stories that go around and you are supposed to know the specific cases, but to trace them down by testimony in court as to just what happened as to threats of putting patients in the mental wards, and stuff of that nature—

Q. I don't want rumors.—A. That is why I want to make a statement that it is done. Whether this fear is justified in the minds of the employees and the patients is a matter of opinion. If you go after it long enough you may be able to trace down specific cases.

Now, in relation to the same thing, I know personally of another situation here that I would like to—and I may yet be able to bring to the attention of the Congressman—

Q. May I make this observation, please: Everyone apparently has come up who wanted to testify, and has done so voluntarily. Some



have been very critical; others have been complimentary; all statements being made in the presence of management. I have seen no evidence of intimidation or fear of anyone I have spoken to in this hospital, and I have done it indiscriminately.—A. Personally, I don't think there is any threats, but that is only my opinion. A lot of the patients are too sick to come down here, and many fellows hesitate to come forward, like I did.

Q. Why should they hesitate?—A. That is human nature. You can go up to the wards and talk to some of these men, and you may be able to bring out specific cases instead of rumors. Rumors are no evidence; I know that.

Q. I have been through the wards, talked to the patients, and have spoken with the patients. They have sent for me, those unable to come, and their feelings are generally the same as the witnesses who have testified here. Some are complimentary and others are critical. No one has been able to show me any instances of threats or intimidation.—A. I wouldn't say that any had been made. I don't believe so, myself. But the only reason I mention that is that that belief among the employees and patients does make it difficult to bring out the full truth about it, with no offense meant to the staff here. Oftentimes these things—this red tape, the consequences of it—is not seen at the top. But some of us boys who try to get some little thing done and get tangled up in it, we get so exasperated we give up in hopeless despair and walk out on a. m. a.

The library service. If they could get some of these other books; it is more in the educational program, but there are a lot of books asked for that aren't available here. Whether we work in exchange with another library, I don't know.

Q. Do you know how many volumes they have in this library?—A. No; I don't; but I understand it is a pretty good library.

Congressman DOMENGEAUX. Do you know, Colonel? I understand you have over 10,000 volumes in the library.

Lieutenant Colonel MULLINS. There are approximately that number, or more, over in the main library. How many we have up here in this library, I wouldn't be able to answer that.

Congressman DOMENGEAUX. Over 5,000?

Lieutenant Colonel MULLINS. I should think so; yes.

The WITNESS. The theater here is a topic considerably. We do need something here, a good ventilation system, and the seats in the rear—there are quite a number of them slide off.

Lieutenant Colonel MULLINS. Twenty-five thousand volumes in the main library, and five thousand here.

The WITNESS. I know the management can't do things unless they get the money to do it. There are two shows a week in this theater, and it sounds good, but some of these nights it gets awfully close in here. And because it gets dark late the curtains are drawn and the doors are closed, and it is very uncomfortable. I don't know what kind of ventilation system they have here, but if you could get the money for them you could make a lot of improvements there.

Congressman DOMENGEAUX. Well, I don't know whether good judgment was employed in utilizing these old buildings throughout the years. I think they have done remarkably well with what they have had. Some of these buildings were constructed—



Major FROEMMING. This building was built in 1922, but we do have structures that were built in 1867.

Congressman DOMENGEAUX. That are now being utilized?

Major FROEMMING. Yes.

Congressman DOMENGEAUX. They are not fireproof buildings, are they?

Major FROEMMING. They are not fireproof in the true sense of the word. They have been treated, so they are reasonably fire resistant.

The WITNESS. The radio has been mentioned, with one radio program. Quite often the taste of the man who runs the programs is slightly different from the man lying on his back, and no two men agree on what program they want. If you make several programs available—I just got through an Army school on that subject. They can send a lot of programs over one wire if they can get the equipment. Even the present facilities might be improved on.

Major FROEMMING. Our central office has approved a radio system with three programs, so that the patients may select one of three.

Congressman DOMENGEAUX. That is another one of the things that is being approved right now?

Major FROEMMING. That is right.

Congressman DOMENGEAUX. They waited many, many years to do.

Major FROEMMING. Within the last 3 or 4 months.

The WITNESS. Your investigation has already brought us remarkable results, and I only hope the report doesn't make it so that there was nothing wrong, so that it goes back to the old conditions; that a next investigation will be squelched on the grounds that this investigation didn't show anything wrong. I don't like to blame the fellows here for this, because I understand they are up to their necks in red tape, and if it wasn't for that, they could do a much better job. It seems it goes right on up to the top. That is up to you fellows to see what you can do.

Congressman DOMENGEAUX. Thank you, sir.

(Witness excused.)

Congressman DOMENGEAUX. Does anyone else care to testify?

A PATIENT. Where is Mr. May?

Congressman DOMENGEAUX. Where is Mr. May? Is he in the audience? Has Mr. May been present this morning?

I want to continue these hearings as long as witnesses want to come up and testify.

Mr. MAYALL. You were limited yesterday, according to what you told me when I was up there, by practically the same thing that is holding this institution down, the red tape. There are a lot of highlights I can give you on that subject that possibly hasn't been brought up here.

Congressman DOMENGEAUX. Thank you, sir.

Mr. MAYALL. You want me up there?

Congressman DOMENGEAUX. I don't think that will contribute very much. You were up here and testified yesterday. I think you have been given this opportunity. Do you want to testify about this red tape?

Mr. MAYALL. It isn't red tape; it is the procedure you have to go through to get the benefits you are entitled to according to the laws

of the Congress of the United States. There are three or four channels to go through before you get anywhere.

Congressman DOMENGEAUX. Does anyone else care to testify?

OLLIE JACOBS, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you kindly give us your name?—A. Ollie Jacobs. I have nothing particular to say about the institution here. I have been here about 65 days. The food is very nice here I will say, as far as I am concerned, but I will say I haven't got the cooperation with the place I came from.

Q. From another hospital?—A. From another hospital.

Q. Veterans' hospital?—A. Veterans, Danville, Ill. I was there for 6 years and I cooperated with them—and I think they would say the same thing—as much as possible. There were \$125 sent from my account there to Washington in April of this year, and I tried to get an account of it, but I couldn't get it. In 1941 or '42 I bought \$206.25 in Government bonds. My sister has them at the present time. My physical condition required that I go to a hospital.

Congressman DOMENGEAUX. Gentlemen of the press, I wanted to make a statement that may terminate this hearing, so I hope you will not leave. I don't see anyone else that wants to testify.

By Congressman DOMENGEAUX:

Q. Have you taken that up with your service officers?—A. I have, but I can't get any cooperation with them. I asked the fellow that has charge over there, and he come there and I give him a letter from the hospital there. I think I have a letter here.

Q. I would like very much to help you, sir, but you can well understand that this committee cannot go into these individual cases. I will be very glad to file—A. I have nothing to say about here. They have been very nice to me here, as far as I am concerned. The doctors here, I think, on my ward down there have been very nice, but I can't get any cooperation to get my clothes.

Q. That they have at this other hospital?—A. They have my clothes at the other hospital in Danville, Ill.

Major FROEMMING. We will be very glad to assist this gentleman in straightening it out.

By Congressman DOMENGEAUX:

Q. Take this up with the manager of the hospital, who has volunteered to help you in straightening this out.—A. I appreciate your kindness very kindly.

Congressman DOMENGEAUX. Is there a liaison officer?

Major FROEMMING. We have a contact officer, and he passes through the wards every day to look after matters of this kind. We will be glad to enter into correspondence with the station in regard to this man's case and see if it can be properly adjusted.

The WITNESS. The doctors have been very nice to me.

(Witness excused.)

Congressman DOMENGEAUX. As many as wish to speak, I wish they would arise so that I could get an idea as to how long this hearing will last. Apparently no one further wishes to testify.

(A witness came forward.)

Congressman DOMENGEAUX. Are you the only one? Is there anyone else?

(About three others indicated their desire to testify.)

LEO JOSEPH NOVAK, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, please?—A. Leo Joseph Novak.

Q. Where are you from?—A. I am from Kenosha, Wis.

Q. Are you a veteran of this war?—A. I haven't. I haven't seen no action, or anything, but I came here to the hospital around in February and I came here in the receiving ward and went through the usual routine that most of the patients that come here goes through. After receiving my treatment here and hospitalization, I was transferred over to the company. From the company there I tried to do the best I could over there in getting along with everyone, and I found conditions very satisfactory, and I took it upon myself to take a job as an employee on the pay roll, which makes me what they call a member employee.

Q. How much do they pay you, \$40 a month?—A. They will be paying us \$40 a month. The rest of the employees here, I hear, are getting a raise. And there is one thing that I couldn't get quite straight in my mind—and I have heard a few of the other member employees mention about it—why is it that member employees shouldn't be classified equal to those who are working under civil service?

Q. As I understand, you are not classified under civil service. Maybe you should be. I don't know the type of work.

Congressman DOMENGEAUX. Is there any explanation for that difference of pay?

Major FROEMMING. Right now we are revising our pay schedule based on legislation recently passed by the Congress, and we have complete instructions as to procedure to cover our civilian personnel or the civil-service personnel, but so far as the instruction as to the handling of the member personnel, that has not been released. I called Washington about it the other day and Mr. Collins, Director of Finance, informed me they are negotiating with the General Accounting Office in order to set up an acceptable procedure in order to handle the member employee. As soon as that is received we will make the necessary adjustments.

Congressman DOMENGEAUX. What is the wage scale of attendants?

Major FROEMMING. An attendant comes to us at \$150 a month, and after 2 months of satisfactory service that is increased to \$170 base pay.

Congressman DOMENGEAUX. That is on the present raise?

Major FROEMMING. That is the present raise. Then he is entitled to an increase every year if his services are satisfactory. If he can attain an efficiency rating of "good," he receives an increase of \$5 a month every year.

Congressman DOMENGEAUX. What do your nurses start in at under the new salary?

Lieutenant Colonel MULLINS. It is a little in excess of \$2,000.



Major FROEMMING. A little in excess of \$2,000.

The WITNESS. They also receive periodic increases.

Congressman DOMENGEAUX. Why is it that there is such a difference in the wage scale between the civil-service employees, such as attendants and these—what do you call them?

Major FROEMMING. Member employees.

Congressman DOMENGEAUX. Member employees who average from \$40 to \$50 a month?

Major FROEMMING. A member employee receives his board and room here, outside of the salary; also his medical attention. He is not required to perform the duties a civilian employee is required to perform.

Congressman DOMENGEAUX. Naturally, you have nothing to do with that. That scale is set up in the Washington office.

The WITNESS. That was about all I wanted to bring up.

Congressman DOMENGEAUX. Thank you, sir.

(Witness excused.)

Lieutenant Colonel MULLINS. Mr. Congressman, for a matter of record I would like to state here that yesterday afternoon there was discussion about the chest surgery. I would like to show on the record that we have already accomplished between 30 and 35 chest operations here since we have commenced our surgery.

In reference to the statement made by Mr. O'Connor a few minutes ago regarding the clerical help on the ward, those positions are being filled now and on August 1 there will be clerical help on each ward in order to absorb all this routine paper stuff that the doctors and the nurses at present have to do.

Congressman DOMENGEAUX. Thank you, sir.

ELLIS WELCH, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name?—A. Ellis Welch. My home is in Superior, Wis. I am a diabetic, and a bad one. I was sent to Minneapolis in the veterans hospital, and I got excellent care. I was held up there and they transferred me here, sent me home, and then sent me back here. My own home doctor examined me and pronounced me with a liver and a kidney trouble. I came here. I got good care under Dr. Coon. Dr. Coon was taken off the ward. Ever since they have been monkeying with my insulin, shoving it up and down. And then I got diabetic sores on my feet, and my ward surgeon compelled me to walk to the mess hall with ulcers on my feet, until I took it over his head to Dr. Jones and he took me off my feet and put me on tray. That has been doing on. And now the doctors, every time I complain of my side, they took all my medicine off. Here I am. I am just starting to get treatment again since this investigation started.

Q. How long have you been in this hospital?—A. I have been here 3 years the 18th of this month. They are giving me insulin again. They have changed it again, and I don't know where I am at. My blood sugar has come up. There are a number of doctors that don't understand diabetes. They have a diabetic doctor in this ward, and they won't put him over the diabetics. Why, I don't know.

Q. What is the name of this doctor who is the head of this ward?—A. Dr. Meyer, and I am under him.

Congressman DOMENGEAUX. Who is Meyer? Is he an Army detached officer?

Lieutenant Colonel MULLINS. Yes, but he came to us from civilian life as a commissioned officer. He was assigned to us sometime either in January or the early part of February this year.

Congressman DOMENGEAUX. Medical science is more or less in unison as to the treatment of diabetes, isn't it?

Lieutenant Colonel MULLINS. That is right. However, each case in itself presents its own problems. Some of our diabetics are very easy to control; their doses of insulin are easy to control, and others are not.

Congressman DOMENGEAUX. Thank you, sir.

The WITNESS. These doctors I have been under, Dr. Brenneman, Dr. Buchanan, if I made a complaint of anything ailing me inside, they paid no attention. I have diarrhea. I have had it ever since I come in here. They have not examined me and told me why I have that diarrhea. They don't tell you nothing. They don't tell you one thing. They send you from one doctor to the other doctor, and then he started passing the buck. One doctor says I have no circulation in my legs. The next time I go to another doctor he says, "Nothing is wrong with your legs." I was examined by the best orthopedist, who told me I have poor circulation. Another doctor says I have good circulation, and I have an ulcer on the side of my foot right now and he pays no attention whatever.

Congressman DOMENGEAUX. Will you give us a report of this case, Colonel?

Q. Will you give permission for your record to be disclosed here?—

A. Yes, sir. I have nothing in this hospital that I am ashamed of.

Q. Anything else?—A. I am warning if some of these doctors ever walked down this hallway in the morning at 7 o'clock when they are sorting that dirty linen, and you walk to the mess hall, by the time you get to the mess hall you don't feel like eating after passing that soiled linen or sorting that out in the hall. I wonder if that couldn't be done away with.

Q. Possibly so. Where would they put the linen?—A. In Minneapolis that linen doesn't lay in one room all night. That is taken away and it isn't sorted out in front of where a patient has to lay there and take that smell.

Q. Where is it done?—A. Right up and down this hallway. It is unsanitary.

Congressman DOMENGEAUX. Do you know anything about that?

Lieutenant Colonel MULLINS. This is one of the old-time buildings. Unfortunately, we don't have a laundry chute where each ward is able to get rid of that laundry immediately. The laundry is picked up and taken from the hospital twice a day, in the morning and in the afternoon. It is necessary that this laundry be sorted in the corridor of each ward. That is the only place we have for sorting the laundry.

Congressman DOMENGEAUX. Because of the inadequacy of the building?

Lieutenant Colonel MULLINS. That is right.

Congressman DOMENGEAUX. There would be no other way of doing it?

The WITNESS. The laundry could be put in laundry bags and taken away from here. They don't sort it in Minneapolis. That is done at the laundry.

Major FROEMMING. We submitted a plan to our central office to convert these incinerators that we have in this building, all of which are not required, into laundry chutes. It is a matter of space within the walls of the building. Our utility officer, who is our technical adviser, has worked out a plan which is now in the hands of our construction service. That will enable us to chute the laundry right down from each ward and it will be on the ground floor where it will be handled without disturbing the man in the ward.

The WITNESS. I have great praise for the staff of nurses. They are wonderful nurses. They are willing to do anything for them, but their hands are tied. Miss Metcalfe has got their hands tied. You can't get a change of linen unless you have an act of Congress to get it, because Miss Metcalfe has a certain one to get out that linen. It has to be a nurse. You have got to stand up on the ward and chase up and down to find a nurse to change the linen if you need it in an emergency.

By Congressman DOMENGEAUX:

Q. Do you think you could let the patients go into the linen room?—A. They could have somebody. That lady that handles the linen should be given the privilege to give out linen to the patients if they need it. Another thing—they have only one key for that linen closet. All you hear all day, "Who has got the linen key?" The nurse has to run with the bundle on her back. She will get bawled out if she sets it on the floor. She has to run. They hear it all day in them wards, "Who has got the linen key?" and a hospital is supposed to be a quiet place.

Q. Anything else?—A. From 7 o'clock in the morning to 3:30 in the afternoon it is worse than the Allis-Chalmers boiler works. There is no rest period in the afternoon at all. They will come in with a mop, bump your bed—no consideration for the patient whatsoever.

Q. You mean when they are cleaning?—A. When they are cleaning. They clean plenty. They are scared of Miss Metcalfe. Some of these people don't—

Q. Why do you say they are scared?—A. They are afraid of Miss Metcalfe. You mention Miss Metcalfe, and you will see some of these people get up and dance a jig.

Q. What has she done?—A. She is a good nurse to the patients. She will see that they get all that is coming to them, but she will ride her help, and there are nurses that has left this hospital on account of a nervous break-down through Miss Metcalfe, and I can tell you the names of the ones.

Q. You just stated she was good to the patients.—A. She is good to the patients; hard on her help. She can't help it. If one of them help talk back to her, they ain't here, that is all. I have seen some mighty good help that has been canned out of this place.

Q. Who, for instance?—A. One woman was Mildred Wasielewski. She left because she couldn't—

Q. In what capacity?—A. She was an orderly. She quit herself; she wasn't fired. She couldn't take it. There is a strain there that shouldn't be there. Everything should be harmony. You can feel that atmosphere. You go up there the day when they are having general inspection; you will find every one of them—you mention Metcalfe and you will see them snap to attention. I know. I have been



here 3 years and I have observed all this stuff. There is an atmosphere that shouldn't be here.

Another complaint I have got to make. I have got a son in the Navy; put in 16 months over across. He got a chance to come home on a furlough. He come in here—come in a little late. They wouldn't let that boy of mine come up in the ward to see me—give him a pass. I had to hobble to the front end after that boy came clear here to see me. He couldn't get in the ward to see me. I was supposed to be a bed patient. I got out of bed and hobbled clear to the front end. If you have company to see you and you are on the grounds, you are chased by the guard. "You can't go here; you can't go there." Just by the guards interfering, you can't sit by yourself and enjoy yourself with your company. You have to sit right up within 50 feet of this building. Last year we had thousands of seats. We have 10 or 15 this year.

Q. What happened to the seats?—A. I don't know.

(Witness excused.)

Congressman DOMENGEAUX. I imagine we will adjourn until, say, 2 o'clock.

(Whereupon a recess was taken until 2 p. m. of the same day.)

#### SATURDAY AFTERNOON SESSION

(The hearing reconvened at 2 p. m., Congressman Domengeaux presiding.)

Congressman DOMENGEAUX. Will you come to order, please?

I was given a petition which reads as follows:

We, the undersigned of the dietetic department of the general hospital, wish to submit the complaints with regard to the basement scullery of this department.

1. Insufficient working space for total number of workers.
2. Lack of sufficient ventilation to carry away foul odor of food disposal from returned trays, both general medical and tubercular.
3. Intense heat caused by open steam pipes running through scullery combined with steam from the five dish machines, depriving workers of proper fresh air.
4. Basement floors are constantly wet and strewn with garbage, causing serious foot discomfort.

The previous statements are not intended as a reflection on the department or department heads. We had the assurance from our department head that our efforts at working under these deplorable conditions were greatly appreciated.

They are meant only to better working conditions and facilities for the employees working daily in this scullery.

Your immediate attention on these matters would be greatly appreciated.

This is signed, I would say, by about 25 of the employees. I would like this made part of the record, please.

Would you care to discuss on that angle?

Major FROEMMING. The condition in the scullery in this building is a temporary condition. It is the first step toward the improvement program that we have planned for this building, which involves an expenditure of over \$400,000. At one time we had but one dishwashing machine in this scullery. Now we have four in order to segregate the dish washing between the two sections, and also have separate machines for glasses.

The condition of the floors is primarily due, I believe, to the carelessness of our own people in spilling liquids on the floors. The floors are all tile, to begin with, but in the course of stripping the trays, and so on and so forth, the floors become wet. I would suggest, and have

suggested, to some of our people who work immediately near the dishwashing machine that they wear rubbers during the intense activity in that room. It is a temporary condition and the construction we have in mind will give us a fine scullery in every respect. The floor will be covered by Corey tile, the walls tiled up to a height of 8 feet, and additional hoods will be installed. At this time we have a large suction fan in this scullery. On days of this kind, when it is very humid, it is difficult to keep the aid circulated.

I wish to assure all our people who are required to work in the scullery that their cooperation in this difficult period will be very much appreciated. The condition will be relieved as soon as it is possible to do so in connection with our construction program.

Congressman DOMENGEAUX. Colonel, I have had quite a few complaints from various hospitals and patients relative to their ability to get and be entitled to dental work, such as, I mean, complete denture plates, and things of that kind. What are the regulations, and what is a veteran entitled to relative to teeth?

Lieutenant Colonel MULLINS. Well, our regulations concerning dental treatment are very strict. A lot of times we refer a patient to the dental clinic as an emergency for the extraction of one tooth, and he is told that he need not expect replacement of that tooth. That is in accordance with our regulations.

Now, a patient who comes in here and his teeth are all extracted, his adjunct treatment for some condition he might have requiring prolonged hospitalization, he is entitled to full restoration of his masticating surfaces. A patient who has his teeth all removed at this hospital and goes into some other hospital, he is entitled to have his teeth replaced there provided he stays there long enough.

Of course, at our place here I fall back on that old familiar cry of shortage of personnel. At the present time I have two vacant positions for dentists over there in our clinic. We have 1,200 patients in our hospital, plus the domiciliary load, and our four dentists over here are trying to care for that entire bunch, which is impossible at the present time. They are doing everything possible.

Congressman DOMENGEAUX. Thank you, sir.

Under the present regulations, is a veteran, irrespective of his connections, entitled to come into the hospital when his condition indicates largely that a removal of the teeth and replacement by artificial teeth—can a patient come into the hospital under those circumstances?

Lieutenant Colonel MULLINS. No. We cannot admit him for dental treatment alone, but if he comes in for treatment and we remove all of his teeth as adjunct treatment for some condition he might have, if his condition is such that he is able to go home before the teeth are furnished him we bring him back for completion of treatment, at which time his dentures are furnished.

Congressman DOMENGEAUX. And those have been the regulations for many years?

Lieutenant Colonel MULLINS. For many years; yes, sir.

Congressman DOMENGEAUX. I am just wondering the reason back of such regulations, where the only physical trouble many of these veterans have is bad teeth and are required to be removed and replaced. I am wondering about the narrow view on that, what could justify it, because bad teeth is a medical condition which may under-

mine his general health and make him a very sick man in the future.

Lieutenant Colonel MULLINS. That is right.

Congressman DOMENGEAUX. I was wondering what brought such a condition about. Is it a question of economy? Is it a question of inability to get sufficient dentists?

Lieutenant Colonel MULLINS. That I wouldn't know, sir. However, my opinion is that it is based on the experience immediately following World War I, because our present rules and regulations, with the exception of a few minor changes, have been practically the same since 1927 or 1928.

Congressman DOMENGEAUX. Thank you, sir.

GEORGE LEWIS, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, please, sir?—A. My name is George Lewis, sir.

Q. Where are you from?—A. New York City.

Q. We are happy to have you, and glad to hear your testimony on any subject.—A. It is going to be short and not in the nature of a complaint. I think it is fair to the Administration that I come up here and express gratitude for the treatment I have received in these places for quite a number of years. I have just been recently discharged out of the Army.

Q. Are you a veteran of World War I and II?—A. Yes. Been just recently discharged out of the Army as nothing more being able to be done for me. I come in here and I find out they are doing something.

Q. How long have you been in this hospital?—A. Going on 3 weeks. I just think it is fair to everybody that I testify.

Q. Was your case processed quickly the medical attention rendered to you as quickly as humanly possible?—A. I believe it was. I was in the receiving ward about 5 days; my X-rays, and so forth.

Q. What is your opinion as to the food that is served?—A. It is better than the average Army hospital right now.

Q. Better than the average Army hospital?—A. Yes, sir.

Q. Were you in the Army hospital for any period of time?—A. I spent 7 months in La Garde General a year and a half ago, in New Orleans. I guess you are familiar with that. We didn't starve down there. The food is better here than it is down there. I put 5 months in the regional hospital in Wyoming, and the food is a great deal better here than it is there.

Q. Would you be in a position to express an opinion as to the comparative standard of treatment that one receives in an Army hospital and in a veterans' hospital?—A. When I went in the Army hospital and took an X-ray they told me I was chronic arthritis of the lower lumbar region and nothing could be done for me. I was put on a spinal board. I never received a pill, never asked if I wanted a cathartic, never had my temperature taken from the day I entered to the time I was discharged.

I have to cut this short for physiotherapy treatment. I do think you might take this: The rules and procedure, your committee might do a little revising there and it would help the management of all of these cases.



Q. Do you think if we lose it we would be much better off?—A. Much better. Thank you, sir.

Congressman DOMENGEAUX. Thank you, sir.  
(Witness excused.)

Mr. MAGNUSS, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Will you give us your name, please, sir?—A. Magnuss is my name. I was born in Missouri where President Truman was raised, spent most of my life in Illinois where Abraham Lincoln lived. I have been in the soldiers' home for 6 years, 3 years over at Dayton and 3 years here, and I am worse off than when I came.

Q. Getting a little older, too, aren't you, sir?—A. I am older, and worse off. If all the boys testified that I have heard complain this Congressman would be here until Christmas. A lot of them would be afraid to testify, be afraid of being put out of the home.

Q. Are you afraid?—A. That is why I am here.

Q. Do you think there is any reason for being afraid?—A. That is what they say.

Q. Do you think that is a justifiable feeling?—A. I have carried a petition around here in the soldiers' home and hospital to try to get our Congressmen to favor their veterans more, and a lot of them won't sign the petition because they say, "They are liable to put me out of the home if I sign the petition."

Q. Are there any reasons for their feeling that way? We can't control their conclusions.—A. They are scared.

Q. Why?—A. Well, because they are cowed down and they are scared.

Q. How are they cowed down?—A. Afraid to speak back.

Q. What has brought about that feeling?—A. I guess in the Army they had to obey the captain, and of course here in the hospital, naturally, if you don't obey the doctor you get an a. m. a. and you get sent to ward 26, and over in Dayton ward 7.

Q. Do you know of any case that was sent to ward 26? Why don't we be fair and testify to facts and not rumors?—A. Because I hear them say that.

Q. What do you know of your own knowledge? We can't decide these things on rumors, you know.—A. I am just telling you what I hear veterans tell me.

Q. What do you know yourself about these things?—A. Just what the veterans tell me is about all I know about it. I have asked them to come up and testify.

Q. Can you testify anything of your own knowledge?—A. Yes, sir.

Q. Let's have it.—A. In Company 3 we have 1 bathtub to 180 men.

Q. One bathtub to 180 men?—A. Yes, sir.

Q. That is the home?—A. Yes.

Congressman DOMENGEAUX. What is the correct situation on that? Can anyone give us information on that?

Maj. CLARENCE R. CHRISTIE. That company has one bathtub and two showers.

Congressman DOMENGEAUX. For how many men?

Major CHRISTIE. About 180 men; at the present time about 140 in the company.

Congressman DOMENGEAUX. Is that adequate?

Major CHRISTIE. It is adequate for the use that a great many of the men put to it. It wouldn't be enough if they all bathed as often as they should or as we ask them to.

Congressman DOMENGEAUX. Does the lack of such facilities discourage the men from taking a bath?

Major CHRISTIE. I have been here about a year and a half, and I have never yet gone into that company, or any other companies, and found a man taking a bath in the afternoon or evening. I have never had any complaint about the adequacy of it. We have had some complaints because the water got too hot once in a while, but that was all.

Congressman DOMENGEAUX. You have 1 bath and 2 showers for 140 men now, and at times 180 men?

Major CHRISTIE. That is right. Pardon me; we have four showers. I forgot the one in the new part.

By Congressman DOMENGEAUX:

Q. Four showers and one tub?—A. Yes, sir. Those showers are on the same circuit with the toilet flush and if someone flushes that toilet when you are taking a shower you almost scald to death, and if the kitchen is using the hot water you almost freeze. The engineers that built it don't know how to fix a shower. A lot of them are afraid to take the shower because they get scalded.

Q. But they do have four showers?—A. Yes, sir, four, but you wouldn't want to take a shower in one.

Q. Why not?—A. You are liable to get scalded to death. You have to have your hand ready to be quick on the trigger.

Congressman DOMENGEAUX. What is the situation on that, sir?

Major FROEMMING. Company 3 is located in a building that was built in 1867. The company has, however, been modernized, and it is true there is a fluctuation in the water pressure on these grounds. The pressure available here is 85 pounds to the square inch, which is very high, and we aim to use that pressure to the best advantage of the need that we have in any of our structures. In spite of what we can do, there is bound to be a slight fluctuation in the water pressure which will affect either the hot or cold side. However, all these showers are equipped with thermostatic valves which prevent scalding. Only in extreme conditions is there a possibility of scalding, and then it would be a failure of equipment at that particular moment. These thermostatic valves are carefully inspected and adjusted, and are very safe to use when operated.

Congressman DOMENGEAUX. This condition is true only of that unit, or have you such a condition in other buildings?

Major FROEMMING. We have never experienced that condition in this building here, but we do experience it in buildings of the height that our building is in which Company 3 is located. That company stands on a high point, and it is about six stories high. Of course, the elevation affects the equalization of water pressure.

This matter has been under consideration for some time, and adjustments have been made, and at this time a complete plan is in the hands of our Central Office with a view of revamping the entire piping system in order to make doubly sure we will not have accidents.

Congressman WASIELEWSKI. Have you had any scaldings as a result of the use of these showers?

Major FROEMMING. There have been scaldings here, according to the records, but not any of recent date that I recall. The scaldings we have had were due to failure of the equipment at the moment when the shower was in use. We had one case where a man was paralyzed on one side, and he took a shower and, of course, could not feel the hot water and did not make the adjustment, and the result was there was some scalding. That was some time ago, as I recall.

Congressman WASIELEWSKI. You haven't had any trouble recently?

Major FROEMMING. There has been no recent trouble.

Congressman DOMENGEAUX. This condition was reported to the Washington office?

Major FROEMMING. They have complete facts.

Congressman DOMENGEAUX. When for the first time?

Major FROEMMING. It was reported, I would say, about 4 months ago.

Congressman DOMENGEAUX. That condition has been in existence since the building has been there, or since it has been remodeled?

Major FROEMMING. Off and on we have had difficulty with the water pressure. The water pressure affects the flow of either hot or cold water, depending on which side is heavily drawn on.

Congressman WASIELEWSKI. Do you suppose that mechanical difficulty might offer a mental hazard to the men who want to take a shower?

Major FROEMMING. There is a possibility of that, especially with rumors floating around—and there are a lot of rumors in a place like this.

Congressman DOMENGEAUX. It isn't a desirable condition.

Major FROEMMING. Not by any means.

Congressman DOMENGEAUX. It should be corrected.

Major FROEMMING. It should be; that is right.

By Congressman DOMENGEAUX:

Q. But the war is preventing us from doing it.—A. We had the same condition over in Dayton before the war. I was over there 3 years. One Spanish War veteran called, "Come get me out of here; I am scalding."

Another complaint I want to make. We are put all in the same ward, no matter who you are. Maybe an alcoholic addict is put in the bed next to you. Maybe a tobacco smoker is put in the bed next to you. Maybe an atheist is put in the bed next to you. Do you know what an atheist is?

Q. Yes; I have an idea. Do you think that may disturb anybody's mental condition?—A. I don't like it at home.

Q. This is a free country.—A. You have free speech, and I don't like to hear swearing and vulgarity.

Q. A man in the Army after a while is kind of hard.—A. They call it a home and they jumble—I have taken a lot of cursing in the home, and in Dayton, why—

Q. From whom?—A. Patients.

Q. Patients, not the officials?—A. Yes.

If I slap them they give me dump duty. I have seen that happen.

Q. What will we do with these atheists? Should we let them come



in the hospital?—A. I think they ought to be put in a room by themselves.

Q. Maybe you are right.—A. When I sit down and read my Bible, I hear swearing going on.

Q. I suppose the atheists would object to being next to you with the Bible.—A. Sure.

Q. All right. What else have you got?—A. You hear lots of quarreling in the rooms because some are warm-blooded and some are cold-blooded.

Q. Would you separate the cold from the hot?—A. Some wants the windows open. I have to move because I am under the window.

Q. You will admit with me, I believe, that with such differences of temperament it must be pretty hard to satisfy all these people.—A. It is the way the rooms are built. Some fellows are in a draft and they catch cold. Other fellows are sweating because they are in the corner where they don't get any fresh air. I have heard that quarreling ever since I have been in the home.

Q. Some want fresh air and others don't?—A. Yes, sir.

Congressman DOMENGEAUX. You can have your job, Major.

Q. How are we going to prevent that?—A. That is what you are supposed to do.

Q. How is a hospital going to give fresh air to some, and prevent others from having fresh air? You think Congress ought to attend to it.—A. That is why you ought to earn your pay. You got voted for a raise. You ought to earn your pay. [Laughter.]

Q. I kind of stuck my chin out. A. Yes. About the food, some of the Navy men are burned out on beans. I am not a Navy man, but I associate with them. The days they serve beans, that poor man I feel sorry for him.

Q. He won't eat beans?—A. Yes. I have got some Jewish friends. They serve ham some days. I feel sorry for them.

Q. What about these Catholics on Friday?—A. They serve fish here, but the fish they serve here I wouldn't want a dog of mine to eat.

Q. They served fish yesterday. Is that about the kind?—A. It wasn't in the company I was. I didn't care for it.

Q. General mess over there?

Congressman DOMENGEAUX. Where did I eat yesterday?

Major FROEMMING. Company 8.

By Congressman DOMENGEAUX:

Q. I had white fish which I thought was delicious. I admit if you eat fish too often—I think the fish yesterday was certainly good enough for a dog to eat.—A. In Company 8 and in the general hospital you get better food.

Q. Yours would have to be much, much worse not to be fit for a dog.

Major FROEMMING. The diet in Company 8 and the general mess is exactly alike.

Congressman DOMENGEAUX. That fish yesterday was about the average type of fish you get?

The WITNESS. Sometimes it is worse, and sometimes it is better. I like fresh white fish; yes, sir.

Congressman WASIELEWSKI. I don't care for fish, personally.

The WITNESS. It makes it bad on the men that don't care for fish. They have to eat fish, if there is nothing else, on Friday.

By Congressman DOMENGEAUX:

Q. I thought the fish was rather good yesterday.—A. Maybe you was real hungry. [Laughter.]

Q. I am going to quit questioning you.—A. They have plenty of roaches over there.

Q. They don't feed you that.—A. There are plenty of them there. Go in the washroom at night, you think the roaches was taking the place.

Q. They are only bad at night?—A. They are worse at night. Of course, I have killed a few roaches on the table there. I happened to work 2 years ago in annex 2, and I used to help kill roaches over there. Lots of roaches in the soldiers' home.

Q. Is an effort being made to get rid of them?—A. The doctors don't seem to know how to be able to handle a roach. [Laughter.] I spent 3 years over at Dayton, 3 years here. I was in the hospital over there, and lots of roaches there in the hospital. I begin to think that they follow the soldiers wherever they go; the roaches go along. [Laughter.]

Q. I think roaches are not too exclusive. I have seen them following politicians sometimes.—A. You are speaking about the food. You have detail men handling the vegetables, and some of them—I think they are a little careless about examining them before they let them handle the vegetables.

Q. You mean the attendants?—A. Yes, sir.

Q. In what way?—A. Some of them are tobacco chewers. Tobacco chewers aren't exactly cleanly.

Q. You think the tobacco chewers should be excluded?—A. I have seen them spit on potatoes—where they were peeling potatoes right in the hospital. I shouldn't have told these fellows here in bathrobes that might not like potatoes. They spit right in the potato peelings. They have a big trough where they peel potatoes.

Q. Did you report that?—A. No, sir.

Q. Don't you think you should have reported that to the management?—A. I couldn't do anything about it myself, anyway.

Q. What else?—A. I have told you enough, haven't I?

Q. Tell as much as you know. I want you to have every opportunity.—A. I have been examined every time by the doctors, and each one tells me somewhat differently. In Fayetteville, Ark., they told me I had arthritis. I went to Dayton and they said I didn't have any. Here they tell me I have got it.

Q. Could your condition change in the interval?—A. Same feeling I had when I went the other place. I have enlarged colon. They call it nervous condition, but they don't cure the colon.

Q. A colon is usually associated with a rich man's living, rich eating, and things of that kind.—A. When I was in France and going hungry—it bothered me ever since. They call it nervous condition, but they do nothing for you.

Q. What could they do? Could medical science do anything?—A. I wish they would, but I have fooled around in hospitals and homes, and getting worse all the time.

Q. Thank you very much, sir. If there is anything else you want to contribute—A. If you happen to find anybody to kill roaches, send them around.

Major FROEMMING. With reference to roaches, we do not deny that we have a roach here and there, but we use modern methods of combating roaches. Roaches come into our institution with supplies, and some of them perhaps breed here. We use a vaporizer that uses steam as a vehicle for the fluid and it is very effective, and I can say in all truthfulness that in our general mess, where we have our largest kitchen and our largest dining room, there have been many times when we have offered 5 cents apiece for roaches if any of our employees could show us a roach.

Congressman DOMENGEAUX. I want to make this observation, that I have been around the hospital for 5 days, and I don't know whether roaches are concerned whether a congressional investigation is going on or not, but I will say that in those 5 days I have not seen a roach in the hospital. And if I had seen one it would not have reflected against the hospital, because I doubt that they could be kept away. I have looked for them, and I have not seen one roach since I have been in the hospital; that is 4 days, and I don't think they are keeping away because of this congressional investigation.

(Witness excused.)

Congressman DOMENGEAUX. Is there anyone else who would care to testify?

JOSEPH DE MONTMOLLIN, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, sir?—A. Joseph de Montmollin. I have no complaint, sir. I don't see why this meeting should be held here, because there are no complaints.

Q. We have plenty of complaints. Whether they are true or not is a different proposition.—A. I haven't been here long, but if you kid around and stick with them, and everything else, you won't have any trouble. The doctors here, for instance, you talk to them—sure, they are the best buddies. The only doctor I have had is Sanfelippo, and a few others. Colonel Slaney—he operated on me and did a good job. They mentioned a butcher house here. This is no butcher house.

Q. You think every man is given every possible consideration that can be given to a veteran in this hospital?—A. I got a little mad. I blew up a couple of days ago. I got mad because they wouldn't let me out of the chair. If I got up I would break my feet open again. That is what a few of them raise cain about, because they can't do anything. I was in here—Lawrence is a buddy of mine; in the war together. Sir, we were both in the same room and had the same doctors. I know most of the people around here. They know me on account of the wheel chair. I run everybody nuts around here with it.

Q. You got mad because they would not let you get out of your chair?—A. I don't blame them.

Q. It was definitely to your interest not to let you get out?—A. It was.



Q. And how did they react when you got mad? Did they get mad, too?—A. He said, "If you want to go home, I will take you there." That is all there was to that. Talking about the food and the flies, I got gypped then. I didn't get any flies.

Q. You are not disappointed about that, are you?—A. I expected to have flies, sir. I went this afternoon, and I couldn't find any.

Q. Couldn't find any?—A. No; gypped. And a lot of other things here, a lot of things they can't control, like the bedbugs, they say. Jail houses have bugs. What happens? They train them to carry cigarettes back and forth. Why not have the patients train them?

Q. Have you got bedbugs in this institution?—A. No. I have tried to find one, and I can't.

Q. They are not hard to find if they are there.—A. I think they find you. So why should a meeting be held like this when there are no squawks—any squawks?

Q. That is the American way of life, you know.—A. If they want to find out the real bottom to this thing, why don't they put in a few veterans from Washington, D. C., and put them in the hospitals around and let them listen to some of the guys talk, and they will find out, by golly, there isn't anything wrong—not a thing wrong.

I know Metcalf, sure; I don't know her personally, I know of her. I know she is a swell woman. And the nurses, they are all nice. There is a lot of them that is not. You can't help that; that is nature.

Q. You have nurses who are pleasant by disposition and others who are gruff. You have doctors the same way, just like you have people. In other words, the personnel of this hospital is a cross section of the characteristics that you find in people outside of this organization.—A. My wife don't treat me as good as the nurses do. What the dickens. She won't even give me a bath, and they do.

Congressman DOMENGAUX. Well, thank you very much.

(Witness excused.)

Congressman DOMENGAUX. Anyone else care to testify?

Is Mr. John L. May in the audience? I don't want to leave here without giving him that opportunity to testify.

ANTON F. MIKOLAJCZAK, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGAUX:

Q. Give us your name, sir.—A. My name is Anton F. Mikolajczak. I am in Company 6 here. My grief is this here: I came in this home about in 1942 and everything is satisfactory, but what I think according to my idea, what I saw in the companies been acting a different way, you see. I really think it would be some sort of, something like basketball, tennis, swimming pools, or anything of that sort, because here in these companies they are doing some work, detail work, like 3 days, 4 days, little work they do. In Company 6 I am working regular as a janitor. That is hard work. I don't get enough time to go out and do those things. You take men in these days, if there was some sort of indoor gymnasium they could relax and it would help them mentally and physically. Some men like to swim; others like to box, others like to play a little indoor ball, or something like that. That is my argument.

Congressman DOMENGEAUX. A man to be eligible to come into the home must have a certain percent disability, must he not?

Lieutenant Colonel MULLINS. No.

Congressman DOMENGEAUX. To what percentage?

Lieutenant Colonel MULLINS. A man, to be eligible for a home, must have disabilities existent which would keep him from earning a living on the outside.

Congressman DOMENGEAUX. Which would be a substantial disability?

Lieutenant Colonel MULLINS. That is right.

The WITNESS. Most of the men disabled. If they come in here they sit around all day long reading papers and reading magazines and books. If there was something like that out here, some gymnasium—a man gets tired of reading—a man could go down there and box.

Congressman DOMENGEAUX. Or a little football.

(Witness excused.)

A PATIENT from the floor). May I ask you a question? Do you think it is right to have a clothes allowance, and charge one man for it and another man they don't charge for it?

Congressman DOMENGEAUX. No.

A PATIENT. I have been coming in and out of here for the last 6, 7 years. Myself, I paid \$12.06 for clothes that I had. Money was taken out of the pension check without any authority by me, and other people come in here lose clothes, and everything else, and never paid a penny for it. Another guy lost a pair of gloves, a suit of underwear, and has to cut grass at the rate of 50 cents a day to pay for it. Do you think that is right?

Congressman DOMENGEAUX. Is there any foundation for a statement of that kind? There can be no inequity——

A PATIENT. Here is a receipt right here for \$12.06. Is that enough foundation?

Congressman DOMENGEAUX. I didn't mean that, sir.

Will you give the regulations pertaining to that, please, sir?

A PATIENT. It is not paying for the clothes that I kick about. It is to treat each and everyone alike.

Congressman DOMENGEAUX. It is certainly meant that they should be.

A PATIENT. That is what I am trying to get over.

Congressman DOMENGEAUX. Do you know anybody that hasn't been treated alike, who paid and who didn't pay?

A PATIENT. I paid, for one.

Congressman DOMENGEAUX. What other fellows?

A PATIENT. I don't know their names.

Congressman DOMENGEAUX. How do you know they didn't pay?

A PATIENT. They told me they didn't pay.

Major FROEMMING. Clothing is Government property and must be accounted for, even though it is worn out. In fact, when our people receive their initial issue of clothing they sign a statement which puts them on notice that they are expected to account for this clothing. Now, then, when our men leave the facility they are allowed a certain allowance of clothing to protect them against the elements on the outside. We have cases where men take up employment on the outside, work for railroad companies, work in the harvest fields, work in the factories, where they do work that is hard on clothing, and they

are out perhaps anywhere from 6 to 8 months. When they return they are tried for the loss of certain clothing. If they tell us a straightforward story, that while working this clothing was worn out and they were moving along and discarded this clothing, we are authorized to relieve them of responsibility.

If the man, however, tells us a story that indicates very plainly he just threw the stuff away, abandoned it in some boarding house, or other reasons of that nature, then we hold him responsible for that clothing, giving him due credit for wear and tear and reducing the money value accordingly. If the man is able to pay in cash for it, he is allowed to do that. If he has no money, he is permitted to work it out at 50 cents a day.

A PATIENT. I made the remark when charges were made for clothes that they were wore out. I lost all of my clothes in a fire in Peoria, but still I paid for them just the same. I was in a hotel in Peoria, and the hotel burned down. I lost all the clothes I had.

A PATIENT (from the floor). How about bringing up Mr. Mays.

Congressman DOMENGEAUX. I have invited him. Is Mr. John May around there?

A PATIENT. He is out here in the corridor.

Congressman DOMENGEAUX. There can only be one conclusion, if this man refuses to come up and testify, that he cannot substantiate the charges he has made. That is the only conclusion that can be drawn.

Does anyone else care to testify? I am going to have to bring this hearing to an end unless somebody does come up to testify. Oh, this gentleman.

I think we have given the opportunity to anyone who cares to offer any evidence, and that adequate and sufficient time has been given to each witness to express his thoughts as he care to without any intimidation, without any force, and only with one thought in mind, and that is to get down to the facts.

GARABED SIROUNIAN, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, sir?—A. Garabed Sirounian.

Q. Proceed, sir.—A. I have been a patient here three or four times, and I also have been in a company a couple of times. I also worked as an attendant, and every time I come here I have been treated well. I have never seen any fault any place on food, or anything else and, in fact, they treat me too good. Every time I come here I hate to leave.

Regarding this criticism of our chief nurse, I think it is all bottomless lies. I worked under our chief nurse. Of course, she is very strict. She is strict about the cleanliness, and she bawled me out more than once if my tie wasn't right or my shoes wasn't polished just right, or my uniform wasn't spotlessly clean. I am glad she is strict, because if she don't be so strict you have this place like some other places I have seen. The place would be full of cockroaches and flies and everything else.

I have been in the companies—pretty well satisfied over there. I never seen anything wrong. Everything nice and clean. Beds nice



and clean. Of course, the building is a little old. Still, everybody worked together to keep a place clean. I think everything is very satisfactory—and I have seen some other places.

(Witness excused.)

CONGRESSMAN DOMENGEAUX. We have given everybody an opportunity to express themselves.

I have requested Mr. John L. May publicly, when he was present at this gathering, on two occasions to testify. He has refused to do so. I have considered seriously the possibility of filing a contempt proceedings against Mr. May and to hold him guilty of contempt. But I have decided not to do that, because I do not feel that the man is responsible for his actions. I know his previous medical condition, and his conduct is not the conduct of an individual who wants to do the right thing. He has made serious damnable charges against this institution that has left in the minds of the people of this Nation, who have read these articles circulated throughout the Nation, the thought that these hospitals were not proper institutions for their boys to be in. He has had the opportunity to substantiate these charges. He has steadily refused to do so. No one could possibly have a greater opportunity than he. I rather feel sorry for Mr. May, but I condemn most highly this magazine called Reader's Scope that published the article of a man whose actions with this committee certainly indicate that he is not responsible.

Is there anyone else that cares to testify? If there is not, we will have to bring this hearing to a close.

Thank you very much for being present.

(Whereupon the hearing adjourned sine die.)

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MILWAUKEE, WIS., *July 24, 1945.*

TUESDAY MORNING

(The adjourned public hearing reconvened Tuesday, July 24, 1945, in the Lotus Room of the Plankinton House, Milwaukee, Wis., at 10 a. m., the Honorable James Domengeaux presiding.)

CONGRESSMAN DOMENGEAUX. Will the meeting come to order please. This is a continuation of the public hearings that I commenced to investigate conditions at the Wood Hospital in Milwaukee, and to give an opportunity to Mr. John L. May to present whatever evidence he may have in substantiation of the magazine publication published under his name in the Reader's Scope magazine of August, 1945.

I may state that while the public hearings were being conducted Mr. May was given every opportunity to appear and to present his evidence; but, for reasons known to himself, he refused to do so and he is now appearing as a result of a telegram that I sent him dated July 23, which reads as follows:

By virtue of the authority granted to me by Congress as a member of the Veterans' Committee of the House of Representatives of the United States charged with the duty of investigating Veterans' Administration hospitals, you are directed to appear at 8:30 p. m., Monday, July 23, Plankinton Hotel, room 832, Milwaukee, and present whatever evidence you may have with reference to charges made by you.

JAMES DOMENGEAUX, *Member of Congress.*

Mr. May appeared at the designated place, but because of the inconvenience and small quarters I adjourned the meeting to be held this morning in the Lotus Room.

I might state that Mr. May requested the subpoena of certain witnesses, and for the record I have subpoenaed them and they are appearing at my request. These witnesses are Mr. and Mrs. Archie Pearson, Mr. Joseph Brune, Mr. and Mrs. Henry Weber, Mr. Willis Brand, Mrs. Lillian K. Stelter, Mr. and Mrs. John F. Mitchell, and Mr. Joseph Meixner.

Mr. May has also requested that certain employees of the Wood Hospital be summoned, and I did this. The names are Mr. Floyd Gibson, Mr. Frank Frances, Miss Ruth E. Metcalfe, Miss Bessie L. Petty, and Mr. Froemming, manager of the hospital. Dr. Mullins, who is also requested, is unable to be here because of illness.

I will state, also, that Mr. Charles L. Mullen, attorney, of Milwaukee, Wis., is present at the hearing representing the complainant, Mr. May. Were there any witnesses for the convenience that you mentioned last night that you would like to hear first?

Mr. MULLEN. I think Mr. Weber first, because he works nights; and then I have this case of his. I, perhaps, can state this better because I have the file. I can give a brief résumé, and any questions that you want to ask we can get into the record there.

This is relating to the regulation as to subsistence passage. The contention here is, and it will be shown, that Mr. Weber was denied 21 months' meals although the amount of \$157.50 was deducted from his pay, and in addition to the deduction he was compelled to pay State and Federal income tax thereon, although he never received any of the meals. Now, in June 1943 the last pass was issued to him and he was asked then to surrender the pass at the end of June in order that he might obtain the July 1943 pass for the meals. For some reason Mr. Weber felt, this being his receipt, he wanted to retain it, and thereupon the facility at Wood refused to give him any further meals, give him a meal ticket; and that is the rule out there that no one may enter the dining room without a ticket, so, therefore, it virtually prevented him from having a meal. Now, in 1943—

Congressman DOMENGEAUX. Do you know how many employees there are over there who eat there?

Mr. MULLEN. That I don't know.

Congressman DOMENGEAUX. Eat at this table?

Major FROEMMING. Oh, there must be close to 500 employees that take meals there.

Mr. MULLEN. October the 15, 1943—strike that—it is September the 14, 1943, there was a letter addressed to Mr. Paul G. Froemming, manager of the veterans' facility at Wood, signed by Charles L. Mullen as attorney for Mr. Weber, setting forth the complaint that Mr. Weber had been denied his meals for the reason that he failed to turn in his ticket. In that letter it was asked under what law these deductions could be made if the—

Congressman DOMENGEAUX. You mean these deductions?

Mr. MULLEN. No. The deductions from the salary.

Congressman DOMENGEAUX. Income-tax deductions.

Mr. MULLEN. If the meals were not given to the worker or they were in any wise denied him, for any reason, and the answer was there that those were the regulations. Well, then, another letter followed, set-

ting forth an order issued by Charles M. Griffith, Medical Director of the Veterans' Bureau at Washington, dated June 19, 1943. Subject: Subsistence passage. I quote:

When an employee requests permission to retain his pass after maturity date such request will be granted but the expired pass will be stamped on, marked "canceled" in ink, and initialed by the issuing officer when the card for the new month is issued so as to make the expired pass readily identifiable as such to the person checking passes at the entrance to the personnel dining room.

CHARLES M. GRIFFITH, *Medical Officer.*

Congressman DOMENGEAUX. What possible use could the expired pass be?

Mr. MULLEN. Well, that is what I asked the manager in Milwaukee; if he thought that that was a proper restriction to ask for the old pass inasmuch as passes were issued monthly in a different color so as to make them readily identifiable themselves; without any stamping or any initialing by anyone. I also wrote to Mr. Froemming, the manager, and asked why that notice—that I had been informed that that notice that the employee may have his pass back—was not posted on the bulletin board, and I received no reason why that was done; but I received a letter from Mr. Howe, I believe. Is that C. W. Howe, chief attorney?

Mr. HOWE. That is right.

Mr. MULLEN. At the veterans' facility at Wood in which he stated that—

- if Mr. Weber would present himself to the dining room for a meal—  
and I am quoting now—

same would be served to him, the meal punched on the pass and then returned to the file. The current subsistence pass cannot be released to this employee until he presents the pass in his possession for cancellation.

That letter is dated October 15, 1943, or approximately 4 months after the order of Griffith that the passes may be returned. Then, after considerable correspondence passing back and forth between the facility and Attorney Mullen, the matter was then referred to General Hines as of October 28, 1943, setting forth—submitting, rather a copy of all of the correspondence of both parties that passed and then asking General Hines for a decision on a matter of that kind. Well, the answer finally was, after some other correspondence passed back and forth, that Mr. Weber was asked to sign an affidavit at the veterans' hospital at Wood, and not knowing the meaning of the phraseology used in affidavits, Mr. Weber asked that the matter be taken up with his attorney. That was denied him and then Henry Weber submitted an affidavit to the Administrator of Veterans' Affairs at Washington, Frank T. Hines, in which he set forth his position. That affidavit was dated on the 21st of December 1943, and the final letter of that attempting to explain without giving the real explanation, or without giving any definite reason for the withholding of the pass, it finally winds up by saying:

There is, of course, no compulsion upon anyone to enter into or continue in a contractive employment including such conditions.

The conditions were not denied, but just gave the employee to understand if he didn't like them he could move; although they were in direct violation of the order issued by the Chief Medical Officer in June of 1943. I think that covers it.



Then here were some other questions that Mr. Weber felt he wanted to ask.

Congressman DOMENGEAUX. Well, does Mr. Weber care to testify?

Mr. WEBER. Yes, sir.

Mr. MULLEN. Is there anything you want to tell about?

Congressman DOMENGEAUX. Your testimony is an explanation of that which has just been recited by your attorney?

Mr. WEBER. Yes.

Congressman DOMENGEAUX. I see. Now, do you care to testify to anything yourself?

Mr. WEBER. Yes, sir.

Congressman DOMENGEAUX. All right, sir.

Mr. MULLEN. Can we get a chair for him?

Congressman DOMENGEAUX. Yes, sir; that will be fine.

HENRY WEBER, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Congressman DOMENGEAUX. Now, I will be very glad to listen to anything that you have to say. I want to make this statement, and it applies to all the witnesses, that these hearings must be conducted along legal lines; and I am going to ask you to restrict yourself to evidence within your own personal knowledge, of which you can speak of, yourself, personally, and not what others have told you.

The WITNESS. Yes, sir.

Congressman DOMENGEAUX. That applies to all witnesses, and I am going to insist upon that very fundamental rule of evidence which is proper and right. Continue, sir.

By Congressman DOMENGEAUX:

Q. What is your full name?—A. Henry M. Weber.

Q. You are an employee of the Wood Hospital?—A. Yes, sir.

Q. How long have you been working there?—A. Ten years.

Q. All right, sir, now continue. You are a veteran of World War I?—A. Yes, sir. What is the first, I have got it marked down there?

Mr. MULLEN. Oh, no; this is additional testimony.

By Congressman DOMENGEAUX.

Q. I want you to testify to anything that you care to, any criticism of Wood.—A. About 7 years ago I was in ward 15—that was before the 8-hour day come in—and I had a lot of sick patients up there to take care of. I couldn't get my cleaning done so—

Q. Couldn't get your cleaning done?—A. Couldn't get my cleaning done.

Q. Do you mean your work in cleaning the wards?—A. Yes.

Q. I see.—A. So the assistant to the chief nurse came in making inspections.

Q. Who was she?—A. Miss Petty.

Q. I see.—A. We were all standing by the kitchen getting ready to serve dinner.

Q. Who do you mean—"we"?—A. All the attendants.

Q. I see.—A. So Miss Petty started in that she said, "you boys are using dirty mops and brushes. We cannot stand for that in a surgical ward much longer." Then she especially jumped me. She said,

"Miss Metcalfe found dirty floors in your ward last week." So I said, "I am doing all I can. I am not going to kill myself on this job." "Do you want to get discharged for insubordination?" Miss Petty shouted at me. "You report to Miss Metcalfe, the chief nurse." So, at 1 o'clock I reported to Miss Metcalfe and the first thing she said, "I have a report here your floors were dirty. If you can't do it we will get someone who can." Well, while we continued to argue, Miss Petty slipped out of the room and a minute or so later she come back and Dr. Thompson—at that time the medical chief—so Dr. Thompson sit himself to my left, and after a while Miss Metcalfe turned to him and asked him, "What do you think of me—what do you think of him?" Mr. Thompson said, "I think he's said enough," or, "We will prefer charges against him." So I glanced over toward Mr. Thompson, he said, "You have said enough, Weber."

Q. You mean charges of insubordination?—A. Yes, sir.

Q. Insubordination?—A. Insubordination.

Q. Which were before the Civil Service Commission?—A. Well, I don't think that civil service was in effect at that time.

Q. I see. All right.—A. I am not sure, and Miss Metcalfe said, "You go back and clean them floors"; and I said, "Who is going to take care of the patients?" I was the only attendant on the floor at the time and while I was gone there was no one there to answer the lights; and when I said that Miss Metcalfe stamped down her foot, "You go back and clean them floors." So, without saying another word, I walked out of the ward back to—I mean back to out of the office.

Q. Now, let me ask you what is wrong? First, you realize that running a hospital of that kind requires regulations?—A. Yes, sir.

Q. And discipline. Now, from a management standpoint in the operation of such a large hospital, if reports have been brought to the head nurse that you, or any of the employees, were not doing their duty, don't you think that it was her duty to investigate those charges? In all fairness, now, what is so wrong about that particular occurrence? What is so wrong about that? I mean I don't know; tell me.—A. Well, I would like to continue with that.

Q. Well, now, let us restrict ourselves to this particular one; then you can jump to some other. What is so wrong about that?—A. You mean—

Q. The fact that if your floors were dirty and you had been reported by the assistant nurse, and then asked to report to the head nurse, and then you all got into an argument and she told you to go back and do your work and that, because of your insubordination, charges would be preferred against you. From a management standpoint I don't—what is so wrong about that?—A. The wrong is that there is too much work piled on an attendant and it is just impossible to have it done.

Q. Well, that was 7 years ago.—A. Yes.

Q. Before the war.—A. Yes, sir.

Q. The personnel problem was not near as serious as it is today; but if there is too much work on the attendant—and don't misunderstand me, I have very much sympathy for the attendants and I think as a whole the attendants in the hospitals of the Veterans' Administration have done a magnificent job; they have been loyal, they have stuck to their work when they were tempted to go out and

get better jobs in war plants, and I have the highest respect for the attendants and the employees who have carried on during the war and I am sure that they have been overworked in many instances—but I still want to know what is so wrong about that particular instance which would reflect mismanagement on the part of the Wood Hospital?—A. Well, I would like to make myself clear. I didn't say that it was—that was all wrong.

Q. Well, now, and I want anybody to talk as much as they can, but let us be fair about this. There are certain instances that develop in any institution that result in dissatisfaction of those who are involved; but this is a big, tremendous thing, and there are enough serious charges that have been called to my attention, and this committee is interested in the fundamental problems involved. Now, does that indicate that Miss Metcalfe is a dictator or is unfair, or that she was derelict in her duties as head nurse in causing you an injustice or in not carrying on the duties of her office?—A. I would say she's very, very unreasonable.

Q. In what way?—A. That she expects attendants to do the cleaning and take care of the patients at the same time, and it doesn't make any difference how many patients one has to take care of, if he doesn't get his cleaning done, he's called on the carpet.

Q. Well, you find some bosses that are lenient and others who are strict. You find some bosses who can get more work out of their employees than others; and I grant you that Miss Metcalfe, from observations, has been very strict; but I don't know any other way how an institution of that kind could be properly managed unless the regulations were strictly adhered to. I am trying to be fair about that.—A. Sir, I appreciate it.

Q. And I want to know. Now, is there anything else about any other charges that you would like to make?—A. I didn't finish the story, Mr. Congressman.

Q. Oh, I see. Continue.—A. On coming back to my ward lights were on all over.

Q. This was at night?—A. It was on days. It was in the afternoon.

Q. Oh, you mean the lights of the individual bed patient?—A. Yes. I grabbed for a dust mop and walked down the hall with patients yelling for assistance, for service. I couldn't wait on them because I didn't have—I had orders to clean the floors.

Q. In other words, this order, the cleaning of the floors, came before the assistance and help to the patients?—A. Yes, sir.

Q. Well, that is not desirable, and I have heard other instances of that, even at the present time, on rare occasions, particularly, inspection.—A. On another occasion, that was a couple of years later, I got injured. One of the sideboards that we put on beds to protect the patients from falling out of the beds slipped off and hit me on the big toe. So that night, still eating meals there, at that time we were still eating on Government time, so 12:30 while going to supper I stopped in to see the OD. The doctor was in bed and he wouldn't even bother to look at it. He said, "There is nothing I can do."

Q. What doctor was this?—A. That was Dr. McClung; he is not there.

Q. Well, you were not a patient in the hospital?—A. No, sir.



Q. You were an employee?—A. Yes.

Q. Employees are not entitled to medical care there?

Major FROEMMING. Yes, they are; if they are injured in line of duty they are entitled to medical care.

Congressman DOMENGEAUX. All right.

Q. Continue, sir.—A. Well, I didn't think much of it. I thought in a couple of days it might be all right again; but a week or so passed and my toe wasn't getting any better. So one morning, going off duty, I stopped in to report to Miss Metcalfe, and when I said that I stopped in to see the doctor on the night of the injury she said, "but who told you to go to see the doctor? You violated the rules willfully. You know that you should have come and see me first." So I said, "if I was dying in there or if I couldn't walk any more I should wait until the next morning and report to the chief nurse first?"

Q. That was late at night?—A. Yes, sir; that was about 12:30. So then Miss Metcalf sent Miss Petty out to get my record. A few minutes later she come in with the record and she threw it in front of Miss Metcalfe—pardon me—

Q. Surely.—A. Just like this [demonstrating] "Here is the record, give him another chance."

Q. "Give him another chance"?—A. Yes, like me.

Q. That was 7, 8 years ago?—A. About 7 years ago I should say, or 6; I am not sure about that.

Q. Are you still working at the hospital?—A. Yes, sir.

Q. Have you anything else to say, sir—A. Yes. I would like to say a few words about this food.

Q. Now or then?—A. Then. I haven't been eating a meal for over 2 years.

Q. I see.—A. At that time the food as I noticed a lot of times when they cooked vegetables, different kinds of vegetables, they just boil them in water and put them on the table without any seasoning or anything. Well, I can't eat that stuff. At home we used to cook for pigs like that, everything together, and nothing on it, no seasoning, not even salt; but I am a human being.

Q. Well, I have had the misfortune of being in some of the best hospitals of this country and I think it is the practice not to season hospital food very highly. There are others there that don't like seasoning in their—A. Well, we don't do that at home.

Q. Well, I know, but that is a hospital, that isn't home.—A. But why should we be forced to eat when we don't want to eat? I eat at home; I am a man's man, I have a wife and a home.

Q. Yes. Well, those—I don't know about that, but that comes from the head outfit in Washington. Now, what else have you got to testify to?—A. That is about all.

Q. Well, now, you are still at the hospital?—A. Yes, sir.

Q. You have been working there constantly since?—A. Yes, sir.

Q. For these last 10 years?—A. Yes, sir.

Q. And how much are you paid?—A. I would not like to take up too much of your time, or everybody's time, but I would like to start at the beginning, if I may, sir?

Q. Well, we have gone through that.—A. I mean about the wages.

Q. Oh, I see. Well, no, I just wanted to know. What I was trying to determine if these things have been so unpleasant and unsatisfactory to you, why have you continued to work there? I mean,

employment is begging, anyone can find a job where you could make much more money than you could there. I am not criticizing you, I am just trying to understand why, if these things were so distasteful to you, you continued to work there?—A. Well, wages were certainly not the object. I may have personal reasons for staying on that job; but wages are not the reason.

Q. I understand.—A. Now, to answer your question completely, my check now for two weeks, is \$60.05.

Q. Well, thank you very much, sir. I appreciate your testimony.—A. Yes, sir.

(Witness excused.)

Congressman DOMENGEAUX. Will you take the stand, Mr. May, or have you any suggestions, I mean?

Mr. MAY. Well, I am agreeable to do whatever you think.

Congressman DOMENGEAUX. Well, appreciate that.

Major FROEMMING. Mr. Domengeaux, may I ask a question?

Congressman DOMENGEAUX. Yes, of course.

Major FROEMMING. Will Miss Metcalfe be able to make a statement with reference to the allegations?

Congressman DOMENGEAUX. Why, of course. I think it may be proper to make it now if Miss Metcalfe cares to?

Miss METCALFE. Do you want me to come up there?

Congressman DOMENGEAUX. You might sit over there.

RUTH E. METCALFE, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Congressman DOMENGEAUX. Now, we are going to try and restrict these things to the individual cases, and answer to them, and I think that is the proper way to do it. Everybody is going to have a chance to state their story.

Q. You are Miss—A. Metcalfe.

Q. Metcalfe. You are the head nurse?—A. Chief nurse.

Q. At Wood. How long have you been there?—A. Since 1932.

Q. 1932. Now, for the record, I think that if you restrict your testimony merely to an answer that you would care to make about this particular charge would be the proper thing to do.—A. Yes. The testimony that Mr. Weber gave in regard to the meals is true.

Q. In regards to the meals?—A. Yes. The meal tickets, as far as I know. Of course, we did have orders to pick up the meal ticket and the time that he spoke of that, Dr. Thompson was present, was when I had attempted to get the meal ticket. That was proposed to me, my particular work at that time was to pick those up, and he became very indignant and became quite abusive, and that was the reason that Dr. Thompson made the statement that he thought he had said enough.

Q. Abusive, in what way?—A. Well, he began talking in a loud voice, and telling us what he thought of the institution and of us; but we knew that he was a nervous type, and we sent him back to his work. Mr. Weber has done good work out there; and the incident that he speaks of on 15, I don't believe that there was ever a time when we only had one attendant on 15. I don't think that is possible in the daytime. It is a heavy surgical ward, and I don't believe that was

possible. I can't remember each instance in which I have talked to him about this work. It has been necessary. However, for several years Mr. Weber has been permitted to stay on night duty because he requested it. We have a number of our older men who wished to stay on night duty, and we have given them that privilege. Those who stay and stayed with us, if they want to stay on night duty, we let them. And as far as I can remember I haven't had any trouble or any contact with him for several years. He has made no complaints, and I don't believe that I have had any difficulty with him at all.

(Witness excused.)

Congressman DOMENGEAUX. Well, under any circumstances, I think it is a very minor nature. The instance is purely an administrative job, and I don't see anything fundamental about that situation.

Major FROEMMING. Mr. Domengeaux.

Congressman DOMENGEAUX. Yes.

Major FROEMMING. If you please, may I make a statement with reference to the incidents related by Mr. Mullen?

Congressman DOMENGEAUX. Yes.

Major FROEMMING. The system of serving meals is laid down to us by our central office in Washington. It is a standard procedure throughout our service. The hospital attendants and mess attendants are known as food handlers, and are required to take one meal during this tour of duty.

Congressman DOMENGEAUX. How much is the charge of that meal per month?

Major FROEMMING. I believe that one meal costs \$7.50.

Congressman DOMENGEAUX. That is about 25 cents a day?

Major FROEMMING. On a 31-day month, and by skipping 5 meals the meal would cost 30 cents, and by only taking 20 meals during the month the meal would only cost 38 cents.

Congressman DOMENGEAUX. Is there any reason for that computation? I mean the cheapness of the meal of 25 cents, is it contemplated that attendants will miss a few meals each month; is that the idea?

Major FROEMMING. That is the idea. I was told by our central office officials when we discussed the charges for meals that they anticipated that a food handler would miss a certain number of meals, and for that reason in order to save a complicated bookkeeping system of only charging so much per meal, they set the monthly charge at a figure that would be reasonable and the attendant could miss up to 10 meals and still only pay a nominal sum for each meal. The correspondence we have had with Mr. Mullen, and the contacts with Mr. Weber, have been quite extensive. We tried our level best to adjust this matter, and were in constant touch with our central office when the question arose as to whether or not the attendants should turn in this card for the preceding month before they were issued the new card. Finally our central office ruled that the card would not have to be returned to us to file but merely to be stamped "concealed." Now the cards were the same color. They might have a slight variation as to color due to the stock and the printing shop; but there was no difference in the coloring so we had no way of determining which card was from a previous month, and with the rush at the dining-room door it was thought desirable to take out of circulation all cards that were not authentic, and upon which meals should not be served. We tried



to cooperate in this respect and, as Mr. Mullen has stated, we finally got rulings from our central office that eased the situation: and meet these men half way by permitting them to retain this card to be used for whatever purpose they might desire, and we merely asked for the privilege of stamping it "canceled." Mr. Weber was never denied meals. When it became technical grounds where he declined to turn in his card even for the purpose of marking it "canceled," he was notified by our dietitian that his meals would be served to him but the card would be kept on file because he was declining to comply with the requirement to return the card to us. I believe that is all.

Congressman DOMENGEAUX. Those were the rules and regulations?

Major FROEMMING. Yes.

Congressman DOMENGEAUX. And irrespective of whether they are reasonable and logical, you had to enforce them?

Major FROEMMING. That is very true.

Mr. MULLEN. This rule was on the 19th of June; this rule came through giving them——

Congressman DOMENGEAUX. The correspondence indicated that the rule to give them back was, at least, in effect on June 19, 1943, and Mr. Mullen started correspondence in September 1943. Where do you differ from the fundamental statement?

Mr. MULLEN. Well, his statement was that after all this correspondence they got the order through. They got the order through 6 months before this, well, 3 months before this correspondence began they got this order through.

Congressman DOMENGEAUX. Do you follow that, Major Froemming?

Major FROEMMING. Well, I can only say that we placed the modified procedure into effect immediately upon receipt of authority from our central office.

Mr. MULLEN. I just wanted the record to be straight as to or view, that is all.

Congressman DOMENGEAUX. Yes. The whole thing is this: That this may have been an inconvenience to Mr. Weber and the regulations may or may not be reasonable but the regulations were enforced, and Mr. Weber was supposed to live up to them because he was an employee of the hospital. And in all events it is not reflective of any serious situation that requires much deliberation on the part of this committee.

Mr. May, would you like to take the stand now? Or would you care for——

Mr. MAY. Well——

Congressman DOMENGEAUX. Well, I think you had better take the stand.

Mr. MAY. Before I take the stand could I just correct some of this information here on the meal tickets in this discussion here?

Congressman DOMENGEAUX. No, I think not. I don't think it is that important.

Mr. MAY. Well, I think I ought to inform these people here that I put out handbills about——

Congressman DOMENGEAUX. Well, we are not interested in what you put out in Washington. I want the facts, and the evidence and that is what I am going to ask you to restrict yourself to, not to your personal activities. I know that you have been very active in these various movements. I want to suggest to you, as I have to other witnesses,

that we conduct this in an orderly manner as possible, and that you restrict yourself to matters within your own personal knowledge and not hearsay evidence or things that may have been told to you.

JOHN L. MAY, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Now, I am going to examine you first, Mr. May, about this article that you wrote in Reader's Digest.—A. Correct that, Reader's Scope.

Q. Yes, Reader's Scope, which appears in the first part of the article. [Reading:]

Two decades after the armistice, in 1938, I found work back here in the United States among my old comrades as hospital attendant at Wood Facility, just outside the city of Milwaukee. Wood sprawls over land once occupied as a home for veterans of the Civil and Spanish Wars. Today within its walls, are more than 2,000 veterans, diseased, crippled, ill. Not long ago all were dough-boys of '17; now many are GI Joes of Normandy, the Rhine, the Ruhr, Luzon, Iwo, or Okinawa. \* \* \*

I remember Jerry \* \* \*

(His name isn't Jerry. I can't tell you his name, but here in my portfolio is his sworn statement. These are his facts.)

Jerry fought in the last war. One night he avoided a collision with a freight truck by swerving his flivver into a ditch. Damage: One fractured leg. He went to Wood.

"They stuck my leg in a cradle," he writes. "No one paid attention to me for 2 days. The leg swelled, grew black, puffy. Dr. X, passed by. 'Looks like I'll have to amputate,' he says \* \* \*"

Shocked, Jerry fought this decision, then lay for weeks in bitter agony. Bone tissue formed crookedly, because the cradle was improperly adjusted. "You're lucky to have a leg," commented the grisly man of medicine. No X-ray plates were made. One morning, without warning, without anesthesia, Dr. X rebroke the leg, fitted a cast. For 5 weeks Jerry writhed in waves of fire. Gangrene set in at last. Jerry's leg was cut off.

Today Jerry hobbles on a slanting stump, a living example of the callous abuses which make Wood a mockery of America's love for her fighting men.

Q. Now, first who is "Jerry"?—A. Jerry?

Q. Yes.—He was a patient at Wood, Wis.

Q. What is his name?—A. His name was Mr. Arden Fensel.

Q. What is his name?—A. His name?

Q. What is his name again?—A. Arden, A-r-d-e-n Fensel.

Q. And how do you spell his last name?—A. Capital F-e-n-s-e-l.

Q. And who is this "Dr. X"?—A. Dr. X is Dr. Newmann, the man that done the work.

Q. I see.—And immediately afterward when a rumpus started about this thing was transferred out of here. Where he is today I don't know.

Q. That you know of your personal knowledge?—A. Absolutely.

Q. Now, where is Jerry now?—A. I understand he is in California, him and his wife. They should be—

Q. Do you have personal knowledge of this situation?—A. I waited on the patient.

Q. Oh, you waited on the patient?—A. I worked there. I was a hospital attendant for 4 years.

Q. Did you see, and can you state that no one paid attention to him for 2 days?—A. I wasn't working in ward 10 when he was brought in.

Q. You were not working—A. No.

Q. Well, then, how can you make the statement that no one paid attention for 2 days?—A. I have his papers that he wrote up.

Q. He told you that?—A. He didn't only tell me, he wrote it up.

Q. I see. "The leg swelled, grew black and puffy." Do you know that?—A. Yes.

Q. Of your own knowledge?—A. I have seen the leg.

Q. How did the leg look?—A. It didn't look very good.

Q. Are you a doctor?—A. No. Do you have to be a doctor to see if you can tell black from white?

Q. No, but I think a leg that may be broken may grow black and get puffy under the best of medical care.—A. I agree with you on that.

Q. Now, "Dr. X" passed by. "Looks like I'll have to amputate," were you present when that happened?—A. No, I wasn't; there was patients laying in the bed next to him.

Q. "Shocked, Jerry fought this decision, then lay for weeks in bitter agony." Do you know that of your own personal knowledge?—A. Yes.

Q. How do you know that of your personal knowledge?—A. I was working in the ward.

Q. What ward were you in?—A. 14.

Q. What ward was Jerry in?—A. 14, in the east ward.

Q. "Bone tissue formed crookedly." How do you know that?—A. Well, that's the story they told him.

Q. The story that they told him?—A. That is why they wanted to rebreak the leg.

Q. But you said because, "the cradle was improperly adjusted"; how do you know that?—A. Only by what the doctors and the nurses told him.

Q. Told him or told you?—A. Told him.

Q. I see, and then he told you?—A. He told all of us.

Q. And you write this as a fact. Now, "No X-ray plates were made." Do you know that of your own personal knowledge?—A. That's his story.

Q. Did you check up the records to see whether that was correct or not?—A. He signed a written statement on it.

Q. Well, any man can sign any statement but when you make—when you are responsible for an article appearing under your name in a magazine, you should investigate to determine whether X-ray plates were made or not. Do you know that?—A. I am just stating the facts. I think Congress should investigate the rest of it now.

Q. All right. I am going to investigate this; but you have made certain charges. You say, "no X-ray plates were made." Do you know that as a fact?—A. Can I explain myself clearly now?

Q. Answer the question please. Do you know that as a fact that no X-ray plates were made or not?—A. No; I don't know for a fact; I am taking his story.

Q. Now, "Dr. X rebroke the leg, fitted a cast." Now, do you know that case?

Major FROEMMING. No; we were in the dark as to the name of the patient referred to as "Jerry."

Congressman DOMENGEAUX. Well, can I get this man's—Jerry's case? The official records would disclose his situation.



Major FROEMMING. We will bring it in here now that we have the name.

Congressman DOMENGEAUX. Can I get that now because I think the records should explain these things as they are answered.

Mr. BRAND. Do you mind if I say a few things, please?

Congressman DOMENGEAUX. Yes. When you get on the stand, sir,

Mr. MAY. Could I ask my attorney a question?

Congressman DOMENGEAUX. You can, that is all right.

Major FROEMMING. How long was this, May?

Mr. MAY. In 1940, I think it was.

Congressman DOMENGEAUX. The point I want to make is what personal investigation, Mr. May—now, I have heard stories from patients in hospitals that I have visited and have checked up, and have found the true facts to be entirely different than what they have said. In some instances they were true and correct.

Q. What I want to know is what investigation did you personally make before you allowed this article to be published under your name? What personal investigation did you make to determine the truth or the untruthfulness of this?—A. Well, I didn't think it was necessary to make any investigation on that part of it inasmuch as his wife come there every day and was telling us what was going on, and even nurses was telling us.

Q. What nurses told you what?—A. Those nurses there, I don't know who they are now. They was working in the ward.

Q. You have worked there a long time. You have an excellent memory. Who are those nurses?—A. I would rather have Mr. Fensel tell you the story.

Q. Oh, I know Mr. May, but you state this to be a positive fact and one cannot draw the conclusion except that it is a positive fact. I want to know before you made these charges what personal knowledge, what investigation did you make to determine whether this is true or not? You owed that to your reading audience. Now, your publisher made this statement [reading]:

The facts have been checked carefully. So far as we can ascertain they are all undeniably, shamefully true.

These facts have not been checked by this publisher if you are the only source from which he got these facts, and this is serious business; when charges of this proportion are made an investigation should be determined to determine whether they are true or not. Now, we will go on further. We will go to some of these other cases.—A. Can we finish up on that?

Q. Yes. Tell me what you want.—A. I am telling you. I am trying to bring—express myself to the point that when this was presented to back up the article I presented what he had written himself, and signed his own name to; and that I expected that when this thing cracked that all people involved would be subpoenaed and questioned and produce the evidence.

Q. How are you going to subpoena people that you don't even know? I have tried to get the names of some of these people and you wouldn't even give it to me. You said you would give it to me at the trial, and I have asked you to give me the names of the various people to subpoena. I am not clairvoyant; I can't read your mind. I have got to

know the names and the names that are identified by letters.—A. In the first place, we asked for a special appointed investigating committee here because we knew what we was up against here; and it was over 1,100 signers on petitions from the State of Wisconsin.

Q. I am not interested in that right now. Those are internal matters indicating your activities. What I want to know is whether these serious charges, which indicate butchery if they are true, can be substantiated. Now, this case of "Jerry" is as callous and as vicious as anything that I have ever read, if it is true, where this veteran was treated as this article indicates; and I want to know if the only investigation that you made before you allowed this article to be published under your name by this magazine that would go all over the country which indicated as a fact, what investigation you personally made to determine the truth or untruthfulness of the particular case?—A. I honestly and sincerely didn't think it was necessary to make any further investigation after attending the patient and hearing what his wife was saying.

Q. Did you talk—A. And what he wrote and what he himself told me; and I expected to be backed up with the real evidence by having him subpoenaed in here.

Q. The real evidence will be the hospital record, I presume.—A. They can write anything in the hospital record.

Q. Did you talk to Dr. X.?—A. Yes; I talked to Dr. X.

Q. Did you talk to him about this case?—A. Yes. I told Dr. X.: "Dr. Newmann." I said, "I think that's a dirty, rotten job that you are doing," I said, "from what these people are telling me."

Q. But not from what you—how do you know whether it was "a dirty, rotten job" or not?—A. He said he didn't care to discuss the matter with me.

Q. Why should he care to discuss it with you?—A. Well, I am supposed to learn all I can. They tell you that they will teach you to be first-class attendants.

Q. That was a patient's individual case. Why should he discuss it with you?—A. I am still interested in veterans' affairs and the care and welfare of veterans. I have a right to that, haven't I?

Q. Oh, of course.—A. Absolutely.

Q. But you also have a duty, Mr. May, of—A. Protecting the Veterans' Administration?

Q. Well, you have got a big job on hand, Mr. May.—A. Yes, I know; trying to protect them, that is easy.

Q. But you, also, have a responsibility when you take upon yourself the guardianship of the veterans to be very careful about charges that are made, and that you personally investigate charges before you make them which would create an impression that is nonexistent because there is not butchery in these hospitals; there is no brutality in these hospitals; there is no mistreatment in these hospitals except isolated cases. That is my personal opinion of the investigations that I have seen. This article, and others, create the impression that these hospitals are conducted in a different manner where brutality, where mistreatment is rampant and where it is approved by the officials. Now, you know that is not true.—A. I don't like to differ on that but I think we can bring out that there is brutality.

Q. Well, if the "Jerry case" is an instance of the information that you have got to give, I can well understand what the nature of the

balance of this article is going to be. Well, let us continue. "Men whimper and moan, men go mad, men die at Wood." What do you mean by that statement?—A. Well, they do.

Q. Caused from what?—A. Lack of attention.

Q. Brutality?—A. Yes, brutality.

Q. Mistreatment?—A. Mistreatment. They get despondent.

Q. You don't find moaning in any hospital?—A. Oh, yes; you do; certainly you do.

Q. You don't find low morale among patients in any hospital?—A. Yes, I agree with you on that.

Q. You don't find men dying in any hospitals?—A. Oh, yes; you find men dying in any hospital but not among six and seven.

Q. You leave a very bad implication here that these people "whimper and moan and men go mad, men die at Wood" largely because of mismanagement and mistreatment; is that the treatment that you wish to leave?—A. That's the implication I wish to leave, yes.

Q. Now [reading]:

On the surface Wood was—and still is—a spotless, shining hospital, dust-free, polished. No casual observer will notice anything amiss.

I presume that is one in my category.

True, patients wait interminably for examinations, diagnoses are often faulty, nurses and attendants frequently are unable to care for the simpler needs of suffering men. Doctors, nurses, beds are too few, consultations with specialists difficult, research facilities limited.

Now, did you make a survey of the hospital, Mr. May?—A. Well——

Q. What, in all frankness, how can you—and if I am wrong I wish you would correct me—how can you make that general statement with the information you have and the lack of technical knowledge?—

A. Please remember I belong to a veterans' organization, two of them.

Q. Yes, sir.—A. And those things come up at veterans' organizations.

Q. Now, let us get down specifically——A. But let me specify one case.

Q. You mean in addition? We will come to all the cases. I will give you a chance. We are going to discuss on all of them. [Reading:]

Diagnoses are often faulty; nurses and attendants frequently are unable to care for the simpler needs of suffering men. Doctors, nurses, beds are too few, consultations with specialists difficult, research facilities limited.

What do you base that on? I mean it may be true, but I am just wondering how serious your article can be considered by the general public?—A. I think it was serious enough to wake the American public that something should be done.

Q. Anything sensational?—A. I don't consider that sensational.

Q. The American public may believe.—A. I don't consider that sensational, though.

Q. And we are trying to find out whether it is true or not. I can get on top of this building and threaten to jump off, and I will attract half of the people of Milwaukee. That's sensational; but I may go along about my business for many, many years, carrying on my duties and responsibilities, and the honest, right-thinking individual, and no one is ever going to notice me. I want to know what particular qualifications that you have, what survey have you made,



what studies have you entered into that can justify you to have made that statement?—A. By attending American Legion national convention, State conventions, and the Veterans of Foreign Wars; reading the reports that are made.

Q. The American Legion conventions are usually of laymen; is that your qualification to make a survey of, an analysis of that hospital?—A. Not all Legionnaires are laymen; they are doctors and lawyers.

Q. That is the only background that you have that qualifies you to make that statement?—A. Well, I think, I suppose I am required to have more qualifications then?

Q. Yes; I think that when a man makes that kind of a statement he should know what he is talking about, and you indicate that on that score you don't know what you are talking about because you have no background of qualifications for that type of a statement.—A. Reports are in the papers, even in the Milwaukee papers, about the conditions out there.

Q. Yes, you can check up these things in the papers; but what personal qualifications have you got to make those statements? They may be true, I don't know, but what personal qualifications have you got? You pick something you find in the newspaper and reproduce it.—A. I didn't pick it from the newspaper, my friend.

Q. Where did you get it from?—A. Out of the American Legion, Veterans of Foreign Wars, and the Congressional Record.

Congressman DOMENGEAUX. Mr. Schell, would you like to cast some correct?—A. Not always; no. The American Legion convention—

Q. I am just trying to get this, I want to be fair, but I can't say that I am not disturbed by this because impressions have been created by this article. I have mothers write to me and tell me. "I am going to mortgage my home to take my boys out of these veterans' hospitals if they are like what is stated to be in these magazines." and I don't think they are, and I know they are not, and a great injustice has been done to the American public by these sensational charges by people who are uninformed on the subject.—A. There's many a man in the city of Milwaukee and State of Wisconsin that will not go out to this hospital.

Q. Yes. Well, I am asking you your qualifications for making these general, broad statements condemning, viciously condemning practices that prevail. What qualifications have you got to make those charges? I could not give an opinion on military matters or whether General Eisenhower or General Marshall were competent and qualified, or whether their strategy was bad because I am not a qualified man on military matters.—A. Neither am I on Army matters.

Q. But you are on hospital matters and medical matters?—A. I am about the place up here; I wasn't talking about other veterans' hospitals.

Q. Yes, this hospital, that is the one I am talking about.—A. That's what I was referring to, this hospital.

Q. All right. Now, let us get to this case [reading]:

Mr. A: To my personal knowledge Mr. A, an X-ray operator, who opposed Nurse Metcalfe, was ordered—under threat of firing—to take a mental examination, was found "insane," then was yanked by a rope around his belly into the county mental hospital, later taken for a ride to the Wisconsin State line, dumped into North Chicago with a warning never to return. Because he had been adjudged

insane in the State of Wisconsin, he has never returned to his family who still live in Milwaukee.

Who is "Mr. A"?—A. An X-ray operator, the gentleman sitting right back of me here, Mr. Brand.

Q. What is Mr. Brand's full name?—A. Willis A.

Q. Well, we will let Mr. Brand testify, would you prefer that, as to his own personal experiences?—A. Well, I think it would be better, don't you?

Q. Yes, I think so.—A. And directly I'd like to say that Miss Metcalfe was involved with the group that worked these things.

Q. Well, "Mr. A" or Mr. Brand will be given the opportunity to testify in this case. I think that is very desirable. Now [reading]:

Dr. Y criticized handling of psychiatric patients, who, he claimed, were overdrugged and unnecessarily restrained by chains. Temporarily in charge of the psychiatric ward, he unchained patients, limited the use of drugs. One evening he was discovered drowsing at his desk, accused of drunkenness, summarily fired.

What personal knowledge have you got of that case? Who is "Dr. Y" in the first place?—A. Who is Dr. Y?

Q. Yes, Dr. Y. You say Dr. Y. [Reading:]

Dr. Y criticized handling of psychiatric patients, who, he claimed, were overdrugged and unnecessarily restrained by chains. Temporarily in charge of the psychiatric ward, he unchained patients, limited the use of drugs.

Now, that is a serious charge indicating that mental patients there are chained unnecessarily.—A. Well, I had wrote up—

Q. Who is "Dr. Y"?—A. Dr. Y?

Q. Yes. This is under your authoriship, Mr. May, a very serious charge. [Reading:]

One evening he was discovered drowsing at his desk, accused of drunkenness, summarily fired.

because there is only one assumption to gather from this that these mental patients at Wood were being—

chained, overdrugged, unnecessarily restrained by chains—

and this man tried to correct that condition and they fired him from the hospital under the pretention that he was drunk. Who is Dr. Y? I don't know, you say; you must know.—A. Dr. Farisy.

Q. Dr. who?—A. Dr. Farisy.

Q. What is his name? Where is he? How do you spell that?—A. F-a-r-i-s-y.

Q. Where is he now?—A. On the south side, practicing medicine.

Q. Where?—A. At 3420 West National Avenue. I think the man should be subpoenaed in here.

Q. Well, that is the first I have heard of him. Do you have personal knowledge of that?—A. What?

Q. Do you have personal knowledge of that case?—A. Only what was brought to me.

Q. By whom?—A. By the people that worked there.

Q. I know but you are speaking of "Dr. Y." What do you know about this case of "Dr. Y"?—A. I have only known what he told me himself.

Q. Oh, he told you that. Did you check into it to find out what the situation was, if he was dismissed, that he may have given you as an

excuse? I mean you had an obligation to the American public, Mr. May.—A. I worked in ward 26 myself as a hospital attendant.

Q. Yes; but you are speaking of Dr. Y, who was fired there under the pretension of drunkenness only because he was humane and unchained patients. You have a responsibility to the American public when you make those charges. Did you investigate Dr. Y's case?—A. Well, I took his word for it.

Q. Oh, you took his word?—A. Absolutely. I worked there and I knew what had been done to me.

Q. Have you seen chains over there?—A. I am sorry about that; they made a typographical error there; that wasn't my statement.

Q. Oh, they made a typographical error.—A. I said "straps" when I said it.

Q. You find straps in any mental hospital. How are you going to restrain a dementia praecox, for instance, who becomes violently insane from abusing himself or injuring himself, and the others around there unless that man is momentarily strapped? I saw the pictures of that article in the Cosmopolitan magazine by Mr. Maisel where the very same impression was created that these poor unfortunate in mental hospitals were strapped unnecessarily, and in a cruel manner; and I want to say that those things do not exist in the veterans' hospital. They positively don't exist, and you know they don't exist except in those cases where a man becomes dangerous to himself and to others that he is restrained.—A. Could I make a statement now?

Q. Yes.—A. I have worked in ward 26 as the hospital attendant. The chief nurse has come up there and said to the nurse in charge, "What is this man doing in here? Don't you know I don't want him to work in here? You get out of here."

Q. What has that got to do with chains and straps and the misconception that you and these other people have created in the minds of the American public?—A. Because they didn't want you to see what was going on around there.

Q. I have seen a patient at Biloxi, Miss., in a strap but that was absolutely essential. He was a strong, robust young boy of this war who had just the previous day assaulted and came very near killing another patient. He was crazy. He had to be restrained; but it was humane and it was decent and it was proper.—A. To a certain extent it is; yes.

Q. But the misconceptions created that these poor unfortunates are put in chains and they are cruelly taken advantage of, and that is not true in any hospital of the Veterans' Administration of this country. That is not true, Mr. May, and you know it isn't true, and why you people want to create those impressions to break down this institution where the American boys coming back from this next war are going to have to go for medical attention, I just can't understand. I don't know what is back of these theories because there is no brutality as you people mention. If you are a friend of the veteran it is your duty to give these true facts. Now, let us go a little further: "Those who resist Nurse Metcalfe's methods are threatened with mental examination. Others are warned: Let's keep things under our hats—we're all one big family, aren't we?" Do you care to comment on that?—A. In 1941 we started going to the newspapers, holding meetings about the conditions up at the hospital and the way we were being shoved around and abused, and the dictatorial and mental attitudes of the department heads; and the Milwaukee papers car-



ried quite a bit about it at the time. And then a petition was signed asking for a congressional investigation. Immediately, or shortly, thereafter each and every one of those that signed that petition that they could get their hands on was taken down behind the closed door, individually, without any representation.

Q. How do you know each and every one was?—A. Well that they could get ahold of.

Q. Were you there present at every one of these things?—A. No. They wouldn't let us all in together. We asked for a congressional investigation in 1941.

Q. Why?—A. Because we wanted a Congressman to come in here and look around.

Q. Just because you wanted that Congress should come over here and look around?—A. Well, we have a right to petition the Congress of the United States.

Q. Absolutely, positively.—A. But we was taken in behind a closed door individually and I have the statements of some of those people that was taken in behind closed doors.

Q. Well, what is so wrong about that?—A. What is so wrong about it?

Q. I mean what were they trying to do behind closed doors?—A. Intimidate you and humiliate you and degrade you.

Q. In what way?—A. That you was an outlaw because you stood for your constitutional rights, and tell you, "Don't you ever sign a petition again."

Q. Well, it evidently had very little effect because that is about all that is going on up at that hospital is people signing petitions.—A. Yes; there have been a lot of signed—

Q. Yes; no one paid much mind to it. Do you know of anybody that has been dismissed there for signing petitions?—A. A lot of them.

Q. Who, for instance?—A. Who?

Q. Not Weber. Weber has been fighting that for 10 years and he stayed; they didn't kick Weber out—they didn't run him out. I am just trying to analyze them myself.—A. I stayed there until they tried to take me before a mental board.

Q. You were there as a patient on two occasions, were you not?—A. I was there in 1937 for a hemorrhoid operation. I was—because I seen the fear of those people when anybody would whisper, "Miss Metcalfe is coming," and they would tear down the line and around the corners and grab the buckets and the mops and show that they were doing something.

Q. Well, I agree with you that Miss Metcalfe was considered a very strict disciplinarian; I agree with you.—A. And the set-up in Washington and upholding them here.

Q. Well, now, I don't think we can cover over and run this hospital. It has got to be delegated to someone like Miss Metcalfe or someone like you. I don't know, I mean, you realize it has got to be delegated?—A. Yes. It has to be run; yes; but it don't have to be run in the dictatorial attitude and that everybody is crazy that works there. That is the impression that is left.

Q. Well, maybe. Now, let us go a little further. I am going through and try and cover everything. "Attendant C," who is "Attendant C"? Do you know? There was a Congressman that came

before our committee that made certain charges and most of the charges that he made were from unfortunates in mental hospitals, and he made those statements purely on the charges that—the letters that some people sent him—and when he got up before this committee he couldn't back or substantiate one single isolated case, and he certainly discredited himself in the opinions of those who were there. Who is "Attendant C"?—A. Attendant C?

Q. (Reads:)

Attendant C, a veteran of World War I, reports that he underwent an operation for goiter at Wood.

A. That was the man that I asked to come here, Mr. Archie Pearson.

Q. (Reads:)

Two weeks later he fell ill. Appealing for treatment at Wood, he was rejected. He drove 15 miles to a private physician, who correctly diagnosed his illness as lobar pneumonia.

Is he present yet?—A. I don't know if you subpoenaed him yet or not; he lives at Peewaukee.

Q. You were to attend to that, if you recall.—A. I tried to get him on the phone last night.

Q. That was the arrangement, wasn't it, Mr. Mullen?

Mr. MULLEN. That is right.

The WITNESS. I was up to 2 o'clock this morning putting telephone calls through.

By Congressman DOMENGEAUX:

Q. I am not blaming you, but you had taken on the work. The fact that he is not here, is your fault and not mine; is that correct?—

A. I thought at the same time you would contact him, too, I thought.

Q. No. Your attorney is present and he knows what the arrangements were. You agreed to see that your witnesses would be present. Get his name, anyway, and we will get all the facts.

Mr. VOGTMAN. All right.

By Congressman DOMENGEAUX:

Q. (Reads):

A veteran saw two nurses dump a paralytic from a stretcher face down upon a bed. He informed his relatives. A nurse warned him to concern himself with his own troubles.

What is the name of that veteran?—A. John F. Mitchell.

Q. Where is he now?—A. He is in Chicago. And I tried to get the telegraph company to send a messenger out to him. I tried to get the telephone—

Q. Do you know his address?—A. 505 Madison Street.

Q. 505 Madison Street, that will be checked up.—A. I would rather have the man here.

Q. Well, I would be glad to if you had given me—I have been here a week, if you had given me these names I would have subpoenaed him. The reason they are not here—I can't—I don't know these things, what these symbols designate, and you didn't give me the names.—A. I know but here straight for the record now, just keep the record straight here—

Q. Yes?—A. You come to Milwaukee—

Q. Yes?—A. And you send me a telegram Tuesday afternoon.

Q. Yes?—A. After you got here.

Q. Yes?—A. According to the statement in the paper that you sent me a telegram before you left Washington.

Q. No; I sent a telegram to your publisher asking your address so that I could communicate with you when I got to Milwaukee.—A. I couldn't understand why you should send a telegram to this publisher.

Q. I didn't know your address, Mr. May, and I didn't know where you were from.—A. Mr. Rankin had it on file.

Q. Well, I didn't know.—A. I asked to appear before the committee in Washington.

Q. I didn't know Mr. Rankin had it on file. I can possibly understand after—well—A. I spent weeks down there to go before the committee and I was told by Congressmen that I couldn't come in down there.

Q. With this kind of information?—A. Yes—no; I hadn't put that story out yet then.

Q. Oh, the story hadn't gone out yet. Now: "A veteran saw two nurses dump"—now, does it state—this thing creates the impression that this veteran saw these two nurses take a poor paralytic from his stretcher and, just face down, threw him on the bed. That is the impression you want to create, is it?—A. Well, here is the way it happened.

Q. Well, I mean—A. Private ambulance brought the man in and—

Q. Now, do you know that of your own knowledge, that is the point I want to make.—A. I didn't live and sleep up there, my friend. I couldn't see all those things. I had to take these people's word for it.

Q. I see.—A. And I expected them to back it up.

Q. Yes?—A. And I expected to have an honest and unbiased investigation.

Q. I see.—A. With the five-man committee that we asked to have appointed and go into these things before we went out and get these people.

Q. You have refused for 4 years to give the names of these people when various investigators—A. Well, the Veterans' Administration investigator.

Q. Yes. Well, are you going to run this country? Are you going to run the veterans' investigator?—A. No, I am not.

Q. Who is a better people to give it to? You can't believe that there is a conspiracy on the part of everybody, Mr. May.—A. That conspiracy on the part of the veterans that has been in progress for 20 years.

Q. For 4 years people have tried to get you to give the names of people whom you designate, and you would never give out that information so that an investigation could be made.—A. After we was taken in behind closed doors, we should give out all the information?

Q. I don't know how else you are going to.—A. Hitler done that, my friend.

Q. If you are honest and sincere about this, Mr. May, you would want an investigation to be made. You have kept this information to yourself for 4 years. On various occasions you have—A. We didn't try to keep it for 4 years, we asked for a congressional investigation in 1941. Let's get that straight.

Q. It just had to be like you wanted it, otherwise you wouldn't give the information?—A. We didn't want to be taken in behind closed



doors, and asked all these questions. We wanted a public investigation.

Q. Yes.—A. Which we didn't get. They got taken in behind closed doors. Then in 1942, 458 signers of World War veterans and their wives and widows disappeared out of the files in Congress, and then when I go in and ask Mr. Sabbath, the chairman of the World War Veterans House Rules Committee, he says, "We get thousands and thousands of petitions. We get thousands and thousands of names. They don't mean anything to us." Then he turns around and said, "If you expect to get any help from us stay away from the newspapers." That's the kind of stuff we had to fight in Washington.

Q. Just a conspiracy to prevent you from—A. Anybody, not me alone, any veteran that would come to Washington. General Hines wouldn't let anybody in his office. You know why.

Q. Well, I don't know why.—A. Because he got conked over the head with an inkwell, that's why, and I got too much respect for an inkwell to conk him over the dome. I'd rather have him at the table and talk to him. He should be here, Mr. Smiley should be here.

Q. Who is Smiley?—A. Special investigator. Mr. Kennemar and Dr. Martin, they should be here and tell you how they threatened to throw me in jail if I didn't turn the stuff over to them.

Q. Well, you have been making these charges in newspapers, you are very anxious to let anybody see these things except the properly authorized authorities.—A. I still remember what the Apostle of the Oracle done to me, don't I?

Q. What was that?—A. Double-crossed me, and so did our Congressman, Mr. Wasielewski, from the south side, here, after he practically got up on his high horse and threatened to throw me out of his office in Washington because I was molesting him too much.

Q. Did you ever give the names of these people to Mr. Wasielewski?—A. Sure, so he could give them to the Veterans' Administration?

Q. You wouldn't give him the names? You wouldn't give anybody the names.—A. We sent him the petition with 110 signers on it.

Q. I am not questioning him. What I am saying is that for years and years you have been requested to give the names of the people involved in the various charges that you have made so that an investigation could be made, and you have always refused to give the names of these people.—A. Mr. Chairman—

Q. Isn't that true?—A. Mr. Congressman?

Q. Yes?—A. We went down to Mr. Wasielewski's office on the 12th of September 1941, a group of us. He had a stenographer there. He took the information that we give him. We gave him the names and one thing and another. Ask those people to come in here and testify what transpired.

Q. Well, you have refused to give the investigators of the Veterans' Administration the names of the people involved in these various charges from time to time; isn't that true?—A. Yes, and the rules and regulations of the civil service says that any employee, collectively or individually, may present matters to Congress.

Q. I am not questioning that fact.—A. Well, all right. Those are the questions we are questioning.

Q. You have a perfect right to present your claim in Congress, but you also have a responsibility of giving information if you have it at your disposal, and you have repeatedly refused to give the names of people involved in these various charges so that an investigation could

be made. You have refused to give them to me before today. I asked you a week ago to give me the names of these people so that when the case comes up I would be in a position to more intelligently be able to analyze these facts so that I can contact these people; on my own effort, notwithstanding the fact that you would not give me these names, I have spoken to some of these people.—A. I expected that I would be served with a subpoena when you come to town.

Q. Oh, I see.—A. But I wasn't served with a subpoena.

Q. That is the reason you wouldn't give me this information?—

A. No.

Q. I see. All right. Let us go a little further. [Reading:]

A veteran spent 5 weeks in bed, broken leg in a cast. When he complained that he had not received even minimum attention, his wheel chair was taken away. To his objections, a doctor replied: "You either walk to the dining room or starve."

Q. What is the name of that veteran?—A. Right there is the—

Q. Give me the name of the veteran, please, sir.—A. John E. Orłowski, O-r-l-o-w-s-k-i, I think is the name. October 22, 1940.

Q. Where is this veteran now?—A. I imagine he is somewhere in Milwaukee here.

Q. Have you any personal knowledge of this particular thing?—A. I have people that worked with him and was patients there with him.

Q. That was in the same—A. That was in the same room with him, that was there at the time. Those people have probably moved hundreds of miles away from here now.

Q. But you have no personal knowledge of it except what people have told you, and what statements they have given you; is that correct?—A. Well, I could only go by this.

Q. I understand.—A. I couldn't go by any more, could I?

Q. No.—A. If the publisher thought it was good enough, well, I don't know why Congress shouldn't think it is good enough.

Q. Well, that is a matter of opinion, Mr. May.—A. Yes.

Q. Let me ask you, while we are on the question of the publisher, I think I asked you once before. Do you know any activity that the publisher took independently of the facts that you gave him in checking up—A. I do not.

Q. Carefully this article?—A. I do not.

Q. Now they say [reading]:

The facts have been checked carefully. So far as we can ascertain they are all undeniably, shamefully true.

Now, did the publisher take any other independent actions to determine the correctness of this statement beyond that which you told him?—A. Only what he told me in Washington that he was going to check into this stuff further and he was to come out in the July issue with the article, but he didn't come out until August, so I just figured he was checking into things.

Q. Do you want to file this statement with me? I mean if you don't want to—A. Well, I would rather have it read into the record.

Q. Oh, well, that is not a question of that. Do you want to file it with the committee so that we can make this independent investigation?

Mr. MULLEN. Do you have another copy of that?

The WITNESS. I just have the typewritten copy.

Mr. MULLEN. But you have another copy?

The WITNESS. Yes, a carbon copy of the original copy.

By Congressman DOMENGEAUX:

Q. (Reads:)

A veteran who submitted to an operation for the removal of a rectal tumor lay 5 days without attention. When he requested a bath, he was told to bathe himself. He did so, suffering a hemorrhage.

Do you have any personal knowledge about that?—A. No.

Q. You don't have any?—A. No; I don't.

Q. Where did you get the information; from what this veteran told you?—A. Yes.

Q. You checked up on it to determine the correctness of his statement?—A. I figured it was up to Congress.

Q. You made the charges, Mr. May, not Congress, you know.—A. Mr. Rankin wanted to investigate the veterans' hospital, didn't he?

Q. But you made the charges, Mr. May, and not Congress or Mr. Rankin. You take a man's statement and you leave the impression that it is an absolute truth when you don't even investigate to determine whether it is correct or not. I just can't understand that. That, to me, seems very irresponsible; more so on the part of this publisher, incidentally. If you care to file that statement with the committee?

Mr. MULLEN. Well—

By Congressman DEMENGEAUX:

Q. Well, just file it with the committee. I will put that in the record.—A. I don't know which one it is now, it is in here, any way.

Q. I would like to have the statement if you would care to give it to me because we want to check up on these things. You didn't do it, somebody's got to do it. You just accepted it as true. I want to know whether it is true or not.—A. I don't know just which one it is right now.

Q. It is a veteran.—A. I don't know just which one it is here. I have it here somewhere but I can't find it right now. I haven't it among these papers here.

Q. All right.—A. But I will assure you that you will get it.

Q. Now, this instance is correct, Mr. May; I want to be fair with you in some instances. [Reading:]

A doctor experimentally used ether instead of novacaine for a rectal operation. The patient's tender tissues were eaten away: the man lost control of his bowels, developed a cancerous condition.

That happened at Wood. I checked up on it myself. I was able to find that out, even though you would not give me the name. However, it was not an experiment.—A. Well, it—

Q. It was—A. The whispers was that—

Q. Well, whispers—what were the whispers?—A. Among the patients, "Maybe they was trying to save some money for the Government and try an experiment."

Q. And just because of these few whispers you make that statement leaving the impression that these boys are going to the hospitals to be made guinea pigs out of. That is a very serious thing, Mr. May.—A. This same—

Q. I know the case and I spoke to the boy and he admitted—  
A. He spoke to me the other day.



Q. That it was an unfortunate accident.—A. He spoke to me, too.

Q. And the hospital were the first people to recognize it because they have paid this boy compensation for permanent total disability of \$136 a month plus an additional \$50 a month for an attendant. Now, I spoke to him and, as unfortunate as it was, it is a terrible thing to have happen to this poor boy; but it was an unfortunate accident. Novocaine and ether are the very same consistency in color.—A. That is true.

Q. Yes, and by accident of the nurse the wrong bottle was given and the injection of ether was made instead of novocaine, resulting in a breaking down of this tissue, and this boy has had a most miserable time; but it was unfortunate accident which, although not approved, can happen in the very best regulated hospitals. That is not the rule, that is a vast exception, and when it was found out it was corrected. As a matter of fact it was the doctor, himself, who first gave the information to this boy shortly after it occurred. He said, "My God, a terrible accident has occurred."—A. That is true, he did. He is a very good doctor.

Q. Yes.—A. And the same doctor operated on me at one time.

Q. Yes; but still you create the impression that this doctor, for experimental purposes, used ether instead of novocaine in this hemorrhoid operation. Now, you know that is not true.—A. He didn't use it through his own fault; no.

Q. He used it, according to your record, for experimental purposes?—A. That is what they said up there.

Q. That is what who said?—A. The patients and the——

Q. Whispers?—A. The patients and hospital attendants.

Q. If you had spoken to this boy himself, Graff, you would have known that he doesn't believe and knows that it was not for experimental purposes. You create the impression that these boys have got to go there and be made guinea pigs out of, and it is so purely ridiculous to believe that ether from a medical standpoint could be used instead of novocaine because it is known that ethers breaks down the body tissue. Most people don't know that; you probably know that. You know that, don't you?—A. Yes.

Q. But you create the impression that this boy went there and they experimented on him and used ether instead of novocaine, when you know and everybody knows that the Veterans' Administration has done everything in their power to rectify it.—A. Nobody knows that.

Q. Listen, this happened quite a while ago.—A. I know it was quite a while ago.

Q. You should have checked up on it to determine it before you made that statement. That is the thing that I am objecting to, Mr. May, the misconception that you have given to most of these things, and that is a terrible thing because you know, by and large, those things don't happen, and are not condoned in any of these hospitals. Now, let us go a little further. [Reading:]

A doctor had difficulty in injecting a hypodermic needle into a bed-ridden asthmatic patient in the heart ward. Losing his temper, he flung the instrument to the floor, ordered the patient out of bed. The man stumbled 40 feet, fainted.

Do you have any knowledge of that?—A. Only the discussions made at the Veterans of Foreign Wars meeting.

Q. The conversations and talking about going on! My God, Mr. May!—A. The reports was made on it.

Q. There are so many rumors that go around in all of these hospitals. Most of these patients are there for many months; they talk, they have rumors. You know the psychology of a hospital. Are you basing these things on rumors?—A. All right, the Milwaukee Journal wrote the same things weeks afterward, didn't they?

Q. I don't know. Where did you get it from the Milwaukee Journal?—A. I didn't get it from the Milwaukee Journal.

Q. Without trying to pass upon the merit of newspapers, I have known newspapers on so many occasions to be completely wrong.—A. But they didn't criticize them for writing that. We knew it weeks before it came out.

Q. I don't know. This has come to my attention. Where did you get this information?—A. From people that worked up to the hospital.

Q. Well, who told you what?—A. Well, just from what the hospital attendants up there told me.

Q. Some of the attendants. What attendants?—A. I don't know their names.

Q. You don't even know their names?—A. No, I don't.

Q. Did you investigate it personally?—A. What?

Q. Did you investigate it personally?—A. Then I heard it brought up at the Veterans of Foreign Wars meeting.

Q. Because you heard someone talk about it, the names of whom you don't even know or remember?—A. I know who the doctor was, that was sufficient.

Q. And was discussed at the hospital, I mean, at some of these meetings, you make that absolute charge when you don't investigate it yourself at all?—A. I knew who the doctor was.

Q. What is the name of the doctor?—A. Dr. Stein.

Q. What is the name of the patient?—A. I don't know right now.

Q. What direct source did you get that information from?—A. From the reports that was made at the veterans' organizations' meetings.

Q. Have you got any evidence of that?—A. No, but they have. I don't carry all that evidence with me.

Q. You know it was discussed; you know that they were able to establish it as a positive fact?—A. Yes.

Q. You know that they were able to discuss it? Who is? What member, who was head of the Veterans—what is that, Veterans of Foreign Wars?—A. Yes.

Q. Who was the head of that, of the Veterans?—A. County commander was Frank Breske.

Q. Frank Breske?—A. Yes.

Q. And where does he live?—A. Up on the north side here somewhere. They have got the whole history on it.

Q. I want to get it; but you just know what you heard? Just hearsay evidence; in other words, a bunch of rumors, a bunch of whispers, and someone discusses it at a veterans' meeting, and you make the statement creating the impression that—A. Our petitions we asked that and resolutions; asked that Congress establish the truth and falsity of these charges.

Q. No, Mr. May. You write in this article having only one impression. You don't leave it to Congress. You don't leave it to the pub-

lie to determine the truth or falsity; but you absolutely designate it as a truth. No one can help but draw the conclusion that the statements that you make here are true and that you can back them up.—A. All right, then, in that case Mr. Froemming said that they never knew of the doctor losing his temper before, that is the first time.

Q. Well, that is ridiculous, May.—A. That is ridiculous! He's lost his temper many times.

Q. Why many doctors lose their tempers. Doctors are human.—A. Certainly.

Congressman DOMENGEAUX. How many doctors have you got up there?

Major FROEMMING. Over 40.

By Congressman DOMENGEAUX:

Q. Over 40, come from every station of life, every nationality, from every section of this country, and who have all the qualities and faults, probably, of an average person; and you don't expect them to lose their temper occasionally?—A. It is not necessary that he destroy Government property. If it was one of the hospital attendants that done that he'd be in jail.

Q. But the fact that they lose their temper—I am not admitting that this particular thing is true—I can understand how it could happen; but you don't establish the fact that even this is true.—A. I expected the Veterans of Foreign Wars to establish some of these things.

Q. Oh, you do?—A. And the American Legion, from some of the information that they got.

Q. They have testified, I have gotten their testimony, and am going to talk to them and get their testimony; but you are making charges, Mr. May, and you have got to back up these charges.—A. All right, bring those people in to back the charges, then. They got the information, that is where I got it.

Q. You said you heard rumors and whisperings around the hospital. That is a very, very meager and baseless procedure to follow in making charges. You don't say that these were rumors, that these were whisperings, or that you got it from such and such a source. Every one of these things indicates that you have personal knowledge and can prove and establish this. And you leave the impression that these are the rules, that these doctors just go around without any consideration for the care of the patient, and that, because he was having difficulty in injecting a hypodermic needle in this poor asthmatic patient, he loses his temper and threw the instrument to the floor. You know that if it did happen it is a very isolated case, and that the veterans' hospital would not condone such activity?—A. They must have generally condoned it, the man is still on the job.

Q. You don't know whether it was called to anybody's attention? When did that happen?—A. This last February.

Q. This last February?—A. Yes.

Q. Do you know of any such case that has been brought to your attention?—A. And the Milwaukee Journal carried the reports in April.

Major FROEMMING. I will be glad to discuss the case. It was brought to our attention by three members of the Veterans of Foreign Wars. The county commander's name is—what is it Frank—



The WITNESS. Frank Breske—B-r-e-s-k-e.

Major FROEMMING. A Mr. Carey, C-a-r-e-y, and Mr. Schell, they happened to be visiting in our hospital and came to the office and informed us that this had been reported to them. We investigated it immediately and reduced the investigation to writing. We could not establish that the doctor had lost his temper or had flung a medical instrument to the floor. In fact, the evidence shows that he handed this instrument to a nurse who was assisting him. The doctor changed the man's treatment and we included the findings, or the doctor's remarks, on the clinical records on the ward in the proceedings that we followed in investigating this case; and in the end found the doctor not guilty of having lost his temper and flung instruments to the floor. He prescribed properly for the patient, and a copy of the entire investigation, as we submitted it to our central office, was handed to the Veterans of Foreign Wars officials. I believe I handed it to Mr. Schell.

Congressman DOMENGEAUX. Were they satisfied with the report?

Major FROEMMING. They appeared to be satisfied.

Congressman DOMENGEAUX. Mr. Schell, would you like to cast some light on that particular thing?

Mr. SCHELL. Well, Mr. Chairman—

Mr. MULLEN. That is Fred C. S-c-h-e-l-l.

Major FROEMMING. You are the senior vice now, aren't you?

Mr. SCHELL. Past junior vice, Department of Wisconsin, Veterans of Foreign Wars, past, sir. But sometime, I don't know the date exactly, in the month of February I paid a visit out to soldier's home to visit one of the comrades of the post which I belonged to. He mentioned the fact that while I was here I should speak to the member in a bed across the way which he said he had some experience with a doctor, and he wasn't feeling exactly well about the affair. So I spoke to him. I took his name from the bed. Someone from Oshkosh, I believe, and I spoke to him in a friendly manner. I said "What was the matter?" And he mentioned the fact that the doctor, who later turned out to be Dr Stein, tried to inject a glucose solution into his veins but he couldn't find the veins. He made numerous attempts and that the doctor, when he couldn't find the vein, took the needle and threw it in the corner. Well, I went down and I spoke to Major Froemming about that. I believe that was the procedure there; whether I spoke to the county councilman. I am not certain, but Major Froemming invited Carey, who is now the present Milwaukee Council commander, and myself to appear before an investigation board and Colonel Mullins and myself and the attorney—I am sorry I don't remember his name, he is present here.

We went over to visit this particular comrade, together with the witnesses, and they did mention the fact that that's exactly what happened. We went back to the office after a while, made our report to Major Froemming. He certainly was fair in anything that we might have brought to him. I, myself, say this: I didn't come down here for any particular reason outside of the fact I did want to bring some bouquets to the members of the facility at Wood, Wis., because we were down there on numerous occasions, and any time we did have a just complaint I want to assure you, Mr. Chairman, that we had the best and finest cooperation from him. I am not trying to refute any of the testimony that Comrade May is saying here today because

I wasn't with him, I don't know. I will go out there on various occasions, make our visits, talk to the boys, and we do get their story. Now, after this meeting was over and we got a report that the—well, I can even answer that question—the State commander, George Johnson, took the testimony, a number of pages, we took it along to Madison. We wanted to read it, discuss it; but I didn't go any further with it.

Congressman DOMENGEAUX. Well, the investigation was made by the hospital and submitted to your organization?

Mr. SCHELL. We were on the investigation.

Congressman DOMENGEAUX. You are evidently satisfied. Did you all take any steps after that?

Mr. SCHELL. No; we were satisfied that, I believe, Major Stein, like you made the remark, there is different people in this world and perhaps just on that occasion Major Stein had been overloaded with some kind of work. I don't know. I just merely say that I was there and that was the story from this patient on the bed.

Congressman DOMENGEAUX. Thank you, sir.

Q. Now, Mr. May, did you check up that report to determine the finding that had been made after the investigation?—A. Well, the report was that like he stated, that there wasn't sufficient evidence.

Q. Notwithstanding that you create this as a fact when you knew the findings were different, that there was insufficient evidence. You state this as a positive fact when you had knowledge that an investigation had disclosed that there was not sufficient evidence to establish the truthfulness of that statement; is that correct? Is it or isn't it correct?—A. Well, I didn't think the thing was settled then yet.

Q. Oh, you didn't?—A. No; because there was other complaints relative to him.

Congressman DOMENGEAUX. What time do you want to adjourn?

Mr. MULLEN. What time is it now?

Congressman DOMENGEAUX. It is quarter after 12. We will adjourn until 3 o'clock.

(Whereupon the hearing was adjourned until 3 p. m. of the same day.)

#### FRIDAY AFTERNOON

(The hearing was resumed at 3 p. m., pursuant to recess last above noted. All parties present.)

Congressman DOMENGEAUX. I would like very much if you would be kind enough to take the stand.

Mr. FAWCETT. Yes, sir.

Congressman DOMENGEAUX. Mr. May, if you don't mind, this is just a slight interruption.

Mr. MAY. No, sir.

FRANK L. FAWCETT, appearing as a witness herein, was examined, and testified as follows:

Congressman DOMENGEAUX. Just sit down; we are not swearing the witnesses.

Mr. FAWCETT. I see.

Examination by Congressman DOMENGEAUX:

Q. All right. Kindly give me your name.—A. Frank L. Fawcett.

Q. You are a practicing attorney?—A. That is correct.

Q. Milwaukee? At one time I understand you were exalted ruler of the Elks?—A. That is correct.

Q. Have you had occasion to visit the hospital at Wood?—A. I have.

Q. In what capacity, sir?—A. I was formerly the State president of the Elks here in Wisconsin and one of the first things, after becoming exalted ruler, I went out to the Veterans' Administration and saw those in authority to find out how we could be of service to the comfort and pleasure and entertainment of the soldiers, and made arrangements that the Elks would sponsor a show there once a month; and each month on the third Thursday of each month we went there and put on a show for the soldier boys during the winter months in the theater and in the summer months with a band and a choral unit outside; and as well as at Christmastime, went to every convalescing patients in the soldiers' home.

Q. These activities continued for years?—A. Well, I only know of them, Congressman, during my incumbency in office.

Q. I see.—A. They have been going on since I retired as exalted ruler, that I do know; but I do know that they were carried on each and every month during the year and, also, at Christmastime made arrangements, with the cooperation of the authorities at the soldiers' home, every convalescing patient was a recipient of a gift from our lodge and contained 10 separate articles, and if you want them I would be glad, they were wrapped up—

Q. No; it is not necessary.—A. We went out there from 2 to 4 o'clock, went in every ward, stopped at the mental ward and then the tuberculosis ward, and then the various wards in the hospital; and went through every ward and visited those who were bedridden. I imagine that a goodly portion, I wouldn't know whether there were half of them but a large portion of them went in their bedrooms and it was a pleasant experience—.

Q. Yes.—A. That is, for the boys of our organization to do that.

Q. What were the conditions there as to sanitation and cleanliness, if you had an opportunity?—A. I have never been in a hospital that was better, and received perfect cooperation, not only that, but I think the soldier boys would tell you; oh, the thousands and thousands of decks of cards, thousands of magazines and books. We deem it a privilege to do it because of the cooperation we received from the authorities out there, and, also, I know it would be the statement of our military affairs committee of our lodge that you couldn't receive more perfect cooperation from the heads of an institution than we did receive from those in authority at the soldiers' home.

Q. Did you have perfect and complete liberty to visit as you wish or were you restrained in any manner and just shown the things that?—A. No; apparently the bars were down, we weren't—and then we had Major Bond and the little lady, they were married, they were our guests here and we went out with Major Bond and I don't think there was a ward that he didn't visit. He tired all of us out the day we were there with the major.

Q. Did any of the patients there ever complain of brutality, or mistreatment from the officials?—A. On the contrary, what we received was praise of those in authority. They have an organization of women, the Grey Ladies, and we cooperated with them, and it was a pleasure to go there because you can't do much for the boys on



the battle front and to go out there and be of service and to be of help to the——

Q. Would you say that there was a feeling of fear and intimidation on the part of the patients in relation to their feelings of the managers and administrators?—A. On the contrary, very free on our visits there always and, apparent friendliness. I was quite surprised when I read in the paper of it.

Q. You know that serious charges were printed in this magazine?—A. I didn't read them. I have read the papers and, of course, it was quite a shock to me to know that, too, because we looked on it as a very well conducted institution, and having formed that impression from years of closeness with it going there each month and we still go there, but I am not as active as I was during the past year.

Q. Well, that is a very fine comment, sir, I appreciate you coming over and making that statement voluntarily as a citizen of Milwaukee, and one who has an opportunity—A. Yes.

Q. Because of social work of the organization to have had a fair opportunity to observe conditions there. Thank you very much.—

A. Thank you. I am glad to be here.

(Witness excused.)

Congressman DOMENGEAUX. Mr. May, would you want to continue now?

Mr. MAY. I just wonder where my——

Congressman DOMENGEAUX. Oh, your attorney. Well, we better wait for him. Would you want to wait for the attorney, also?

Mr. BRAND. He is my counsel, also.

Congressman DOMENGEAUX. Oh, he is your legal counsel, also. Dr. Bresnahan, are you willing to talk with or without counsel, sir?

Lieutenant Colonel BRESNAHAN. I don't have to have any counsel, if I can have the record.

Congressman DOMENGEAUX. All right, sir.

Major FROEMMING: Mr. Domengeaux, we do not have the written consent of Mr. Fensel, who is "Jerry," to disclose anything from his records. The records were brought down here this morning and Colonel Bresnahan has briefed them and looked them over, and he has a full report of them and in looking it over I can say that we deny the charges in total. It is a technical question as to whether we can proceed to disclose details of Mr. Fensel's hospital record because he has not authorized us in writing to do so which is required under the law. Now, it may be that the jurisdiction of your committee is so far-reaching that you can subpoena the colonel here duces tecum and have him certify from the records, or testify from the records which, of course, he would be very happy to do upon your request to do so.

Congressman DOMENGEAUX. I feel that—I know that an investigating committee of Congress has such authority and I will so subpoena the doctor to state what the hospital records disclose with reference to the case of "Jerry," related to by Mr. May in his article in the Reader's Scope, and identified by him as Arden Fensel, wherein Mr. May stated that this veteran was brought to the hospital with a broken leg and no one paid attention to him for 2 days. His leg swelled, grew black, puffy, and a Dr. X., identified as—who is this doctor?

Mr. VOGTMAN. Dr. Newmann.

Congressman DOMENGEAUX. Dr. Newmann, a personnel of the hospital, passed by and said, "It looks like I will have to amputate it." Well, the record discloses the picture, so will you kindly state what the hospital records show about that case?

JOHN BRESNAHAN, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

A. My name is John F. Bresnahan, B-r-e-s-n-a-h-a-n, lieutenant colonel, Medical Corps, Army, United States. At present clinical director of the veterans' facility, Wood, Wis. This record shows that Arden Fensel was admitted to the hospital on January 28, 1939. That he was injured in an accident and taken to the county hospital in Milwaukee where badly fractured leg was put in a wire splint and from the county hospital he was transferred to the veterans' hospital.

Q. On what date?—A. On January 28, 1939.

Q. And when did the accident occur?—A. The record reads:

Struck by a car at 5:20 p. m., today. Admitted at 8 p. m., from county emergency. Fractured left leg and multiple contusions. Left leg in a splint which was not disturbed.—Dr. L. M. BERGER.

On that date, and presumably at the time he made that note, Dr. Berger prescribed sand bags, both sides of left leg, morphine sulphate, grains a quarter, at 10 p. m., and p. r. n.,—that's necessary—pro re nata—p. r. n.—as necessary. On the next day Dr. Wilson saw him and prescribed morphine grains a quarter every 3 hours.

Q. His leg came there in a cast?—A. In a splint, a wire splint.

Q. From the county hospital?—A. County emergency hospital.

Q. All right.—A. There is a note under the date of January 30, 1939, signed by Dr. Newmann, it says [reading]:

The patient was admitted because of fracture of left tibia and fibula.

Those are the two bones of the leg—

sustained 2 days ago. The leg is enormously swollen and discolored, numerous fractured blebs are scattered over the limb. Some had ruptured and the rest were evacuated aseptically.

That means that he pricked them with a sterile knife.

Q. To relieve the swelling?—A. To relieve the bleb.

Q. The bleb? The blister?—A. The blister [reading]:

The limb was sterilized and sterile dressings applied. The pulsation of the dorsalis pedis and the posterior tibial arteries not palpable.

That is to say that he couldn't feel any pulsation of the arteries about the ankle. And that means that the blood supply of the leg was interfered with evidently at the site of the fracture.

(Mr. Mullen arrived at hearing at 3:20 p. m.)

Q. Would it have been good medicine to remove those splints from that man's leg?—A. As a rule when we get a new fracture sometimes it is done up in a pillow tied on the side and sometimes in a wire splint.

Q. But I mean one coming to the hospital?—A. We leave it alone until the swelling goes down.

Q. I see. Is there any other practice employed? Could anything else have been done?—A. No. You can't put a cast on because then the swelling would go down after the cast was on, the limb would be

loose inside the cast so you always wait for the swelling to go down [reading]:

The limb was immobilized in a splint. He then ordered emergency X-ray, bed rest, a. s. a.—

That is a mixture we have at the hospital—

grains 10, emperin grains 5, p. r. n.—as necessary—for the duration of 1 month and amytal compound capsules—

that is for pain and nervousness—

one at bedtime for 1 month and mineral oil 1 ounce at nighttime H. S., as necessary for 1 month.—Dr. NEWMAN.

Now, he had his X-ray the first time the 30th of January. He came in at 8 o'clock on the 28th and a day and a half later he had his first X-ray.

Q. Is that good medicine or should he have been X-rayed before under the circumstances?—A. Oh, no. You are not going to do anything to that bad leg right away.

Q. I see. The swelling has got recede?—A. Not only that but you have got quite a badly injured patient like that; let him quiet down. You are not going to begin anything in 1 or 2 days. Besides I don't think they probably wanted to move him even up to the X-ray department. They might of brought a bedside X-ray down if they had one at that time. The less you move a leg like that until you know what you are doing the better. He had his first X-ray on the 30th, 1939—30th of January—and that showed left leg had a recent transverse fracture, the shaft of the fibula, the junction of the upper and middle third. Also, a recent complete oblique comminuted fracture at and just below the junction of the upper and middle third of the tibia and that the distal—that's the farthest—distal end of the proximal—that is this way [indicating]—fragment was displaced medially—that is sideways—about  $1\frac{1}{2}$  sonometer and forward about 1 sonometer. He took an X-ray of the left leg, too, and that showed no pathology. He had a second X-ray on March 31, 1939; a third X-ray May 16, 1939; the fourth X-ray June 21, 1939; the fifth X-ray August 30, 1939; the sixth X-ray October 9, 1939; the seventh X-ray November 10, 1939; and an eighth X-ray November 14, 1939. Now, he had plaster cast applied May 5, 1939, and then he had an open reduction—that is, they opened up the side of the fracture—

Q. Disjointed?—A. Evidently was displaced and a metal plate was put in on June 23, 1939.

Q. Was that done with or without anesthesia? In which he said [reading]:

One morning, without warning, with anesthesia, Dr. X rebroke the leg.

A. Well, the open reduction, that is really technically we break it because that is when they pull the fragments up and put in the metal plate, was done June 23, 1939; that was done by Dr. Dieterle, the consulting physician in town, in Milwaukee. One of the foremost orthopedic men in the State.

Q. What is his name?—A. Dieterle—D-i-e-t-e-r-l-e. Dr. Wilson was the anesthetist. The instrument nurse was Gertrude Hayes. The charge nurse was Joy Slocum in the operating room. Now, that was in June but on the 31st of January, which would be about 3 days—that was the rebreaking operation in June.



Q. I see.—A. But on January 31 about 3—

Q. And that rebreaking operation allegedly done without anesthesia was performed by Dr.—A. Dieterle.

Q. Dieterle, one of the outstanding—what is it?—A. Orthopedics.

Q. Orthopedics of Milwaukee.—A. Now, on January 31, 1939, which was 3 days after he came in, they did a wiring operation to try to wire the fragments together. Dr. Newman was the operator. The nurse was Joy Slocum and the anesthetic used was 2 percent novocaine.

Q. Is that an adequate anesthesia for that type of operation?—A. Oh, yes. He had a third operation in which they amputated the leg because there is a note [reading]:

At the time of the rebreaking operation, so-called, they noted a traumatic gangrene had set in then.

His third operation was November 17, 1939, at which time they amputated his left leg and that was done by Dr. Dieterle, orthopedic consultant from town. The anesthetist was—

Q. Who is not an employee of the hospital but is a consultant?—A. Yes.

Q. He is not a regular doctor at the hospital?—A. No, no. The anesthetist was Dr. Wilson. The instrument nurse was Gertrude Hayes, and the charge nurse was Joy Slocum, and the anesthetic used was ether. Now, in addition to that covering the first 2 or 3 days that he was in the hospital which he received no attention, the notes show that Dr. Berger saw him on the 28th, that was when he came in, and prescribed sand bags to both sides of the leg which was in the wire splint.

Q. Act as a pulley?—A. No; just to keep it from moving.

Q. I see.—A. Morphine, a quarter at 10 p. m., and as necessary, and on the next day, the 29th, Dr. Wilson prescribed morphine, a quarter every 3 hours, and the nurse's notes show that Nurse Jane Hogl on the 29th gave him a cleansing bath and alcohol rub; and that later in the day—same day—he was given an alcohol and powder back rub by Nurse Mabel Paten. Those cover the 2 days he was there.

Q. I see. Does the file disclose whether any charges of malpractice, incompetent medical care was ever urged by this individual?—A. Well, in looking over the correspondence folder I found a memorandum from the chief medical officer directed to the manager which summarized the case so that I presume at that time, this is under date of August 1940, there may have been some question about his happiness in the hospital.

Q. Well, could the Veterans' Administration have done anything more to render adequate medical attention and assistance under the circumstances than that which was rendered to this individual?—A. Well, as far as I can tell from these records, and I wasn't on the staff at this hospital at this time, in looking over these records as a physician of some 35 years' experience, that the treatment and attention for the first 2 days he was in the hospital would appear quite adequate.

Q. Patients sometimes have their legs amputated at Mayo Brothers and Johns Hopkins, don't they?—A. Yes. One of our own doctors is having his done this morning.

Q. Is that all?—A. That is all that the record states that I think would be of interest.

Q. All right, sir.

(Witness excused.)

Congressman DOMENGEAUX. Mr. May, will you resume the stand?

JOHN L. MAY resumed the stand, was examined and testified further as follows:

Examination (continued) by Congressman DOMENGEAUX:

Q. Did you hear the doctor testify?—A. Yes, sir; I did.

Q. Have you any comments to make about that?—A. I would like to read his signed statement into the record.

Q. Well, we will take it and file it with the Board.

Mr. MULLEN. Have you got another copy?

The WITNESS. This is all I have got.

Mr. MULLEN. How many pages? We will have a photostat made and see that you get that.

Congressman DOMENGEAUX. Give me that.

The WITNESS. One, two three, and then there is—

Mr. MULLEN. No; go by pages; never mind the half pages.

The WITNESS. Four.

Mr. MULLEN. Four pages; that will be photostated and a copy delivered to you.

Congressman DOMENGEAUX. Thank you, sir.

By Congressman DOMENGEAUX:

Q. All right. [Reading:]

A rheumatic received no food on his first day at Wood, no visit from a doctor or nurse for 5 days. On the fourth day he requested relief from constipation. "You need none," he was told. He demanded clothes, so that he might buy a cathartic at a drug store. "If you go, you can't come back," he was warned. He went, battled for an hour to reenter Wood, and was finally readmitted. For 2 weeks thereafter he was treated for peripheral neuritis. Later, at a private hospital, his ailment was diagnosed as heart disease.

Q. What is the name of that rheumatic patient?—A. Mr. Schell probably can explain that better than I could.

Q. Mr. Schell didn't make the charges, you did.—A. Well, the charges were taken from the Milwaukee Journal.

Q. That is the basis of your information?—A. Yes; that one is.

Q. You don't know the name of the patients?—A. No; I didn't.

Q. Didn't investigate it?—A. No.

Q. Just took it out of the Milwaukee Journal?—A. Well, that should be sufficient, I think.

Q. No; that isn't sufficient. No; I wouldn't think it sufficient. That is the basis of that particular charge?—A. That is—yes.

Q. A statement appearing in the Milwaukee Journal; but you made no personal investigation?—A. Well, I got the information from the members of the Veterans of Foreign Wars talking in groups at meetings, before the meetings.

Q. Did they have any personal knowledge of the situation? Had they made an investigation?—A. They had made an investigation; yes.

Q. They had?—A. Yes. Veterans of Foreign Wars had made an investigation.

Q. You don't even know the name of the rheumatic?—A. No; I don't. I figured that—

Q. You stated: "He received"—as a fact.—A. The investigation that they had gone into the records and find out who he was.

Q. Well, that may have been settled, is quite a while ago and this thing just appeared in this month's—that may have been settled.

Don't you think that you owed it to your reading public to determine what had been the decision of that particular case even by the Veterans of Foreign Wars before you published it? Don't you think you owed that to the American public, making these charges without any foundation?—A. I don't think it was settled, that is why.

Q. You don't know, you didn't even—you have been showing a great interest for all of these veterans and you didn't even have the interest to go and determine whether a charge that you heard by rumors, whether it was true or not. What process of the investigation was taking place when this ambiguous charge was made? Was it at the beginning or at the end?—A. Just started. It had been started but it hadn't been completed, I don't think as much as I could find out on it from the men that stood around in the clubrooms and talked about it.

Q. Just a bunch of men?—A. But I found out from past experience that the minute you start questioning somebody you don't get any more information.

Q. Oh, and then you gathered the balance from your imagination; is that the idea?—A. No, sir; no, sir.

Q. Well, a man has got to get the source of his information, Mr. May—A. The idea is to bring it up so we can find out what really happened.

Q. But you make this as a charge; you say, "A rheumatic received no food on his first day at Wood, no visit from a doctor or nurse for 5 days. On the fourth day he requested relief from constipation. 'You need none,' he was told." Now, you make that as a positive statement?—A. That isn't the first time that has happened.

Q. I am not questioning that. I want to know the basis of this particular charge, and you got it out of the atlas here?—A. I wouldn't say that.

Q. Well, not much more substantial, and you can't go around condemning and criticizing institutions, Mr. May, without having some foundation for it.—A. Well, then, the Milwaukee Journal must evidently—

Q. Do you know anything that was produced in the Milwaukee Journal about that?

MILWAUKEE JOURNAL REPORTER. You have got the clippings.

Congressman DOMENGEAUX. Oh, I have?

MILWAUKEE JOURNAL REPORTER. Yes.

By Congressman DOMENGEAUX:

Q. But you have made those charges and did not investigate the matter?—A. I investigated as far as I could on them. The Veterans' Administration certainly wouldn't let me come in the hospital and ask any questions on them when they met me at the door and asked me to stay out.

Major FROEMMING. Mr. Domengeaux?

Congressman DOMENGEAUX. Sir?

Major FROEMMING. I would like to have Mr. May state when he was ever met at the door and asked to stay out. Mr. May is a veteran and he has a right to come to us for any service that we are in a position to render. He has never been—

The WITNESS. I have been refused passes on Sunday afternoon by the men at the desk.



Congressman DOMENGEAUX. Well, it may not have been visiting hours.

The WITNESS. It was.

Major FROEMMING. If Mr. May had any particular patient to visit he was granted a pass along with hundreds of others that come to our doors on Sunday afternoon.

The WITNESS. I wish Dr. Bernard was here to repeat the statement he made at one time.

Major FROEMMING. Mr. May was guilty one time of coming to our facility and representing he was visiting certain patients and then we received reports from the ward that he was circulating a petition. He was in a ward where we had very critically ill persons, then, that were very, very sick, and a number of these men signed this petition not knowing in their physical condition what they were signing. Many of them after they realized what they had done were so upset about it that it definitely retarded their recovery. I have evidence to the effect over the signature of a former chief medical officer, whose name is Dr. Bernard.

The WITNESS. It left a rebounding effect in Washington, too, but that is the same petition that—

Congressman DOMENGEAUX. No, Mr. May; your activities have not made a ripple in Washington, and if this magazine had not been published, these unsubstantiated charges, and gave you some prominence, this committee would not be taking the pains that are being taken at this time to either have them substantiated or disproved. So don't be under the delusion that your activities have created much activity or concern in Washington because they haven't; they really haven't. These things have been published over the country, over this whole country, and people don't know whether they are true or not. And that is why we are investigating these things.—A. I filed charges in Washington for the petitions that disappeared there out of the files.

Q. What petitions—pertaining to what?—A. Investigation.

Q. Charges like this, ambiguous Mr. X, and Mr. Z and Mr. Y?—A. No, sir. Petitions that were drawn up asking for congressional investigation.

Q. And they disappeared?—A. They disappeared out of the files, and charges were filed with the Speaker of the House on them, and I was told that at the time, as I repeated this morning, that those petitions were inadvertently lost.

Q. Anyone has got the right to file petitions. They may have been lost; they may have been deliberately mislaid, I don't know. What we want to know is whether these charges that you have made are true or not; that's all. Now, "Witnesses state that doctors have referred to patients as 'dirty Jew,' 'damned nigger'." Most of the doctors on the staff are Jews, aren't they?—A. I don't know.

Q. I found over 40 percent of the hospitals that I visited to have Jew doctors.—A. I don't know anything about that.

Q. I found that—A. As far as I am concerned it is immaterial to me what a man is.

Q. I am not questioning that fact. I am trying to determine whether these doctors, and you have just as many Jew doctors, and I am not making any observation on that one way or the other, but I can't hardly believe that these doctors who, if they don't predomi-

nate, are in great numbers, would allow the practice to go on in a hospital where the patients are being called "dirty Jews." How many Jews have you on your staff?

Major FROEMMING. Well, I have never counted them but there are a goodly number. Some of our best physicians are Hebrew doctors.

Congressman DOMENGEAUX. What percentage of your staff are Jews, approximately?

Lieutenant Colonel BRESNAHAN. About 40 percent.

By Congressman DOMENGEAUX:

Q. About 40 percent, and these doctors who run the hospital allow that to happen. Now, "Witnesses state"—what witnesses?—A. I don't know if it is in here or not.

Q. Give me their names, please, sir, and addresses. Do you have their names and addresses?—A. Mr. Brand.

Q. Oh, Mr. Brand, the gentleman who is going to testify afterward?—A. Yes.

Q. Who else?—A. That is the only one.

Q. But "witnesses" is plural. You don't know whether he heard them called "dirty Jews" or "dirty niggers"?—A. No; I don't.

Q. But they said they called patients, and this seemed to be a very common occurrence. "Witnesses state that doctors have referred to patients as 'dirty Jews,' 'damned nigger,'" and Mr. Brand is your source of information on that?—A. On the information that was given to him.

Q. Oh, he didn't—that is hearsay. Someone told Mr. Brand and Mr. Brand told you. I see. Now, I am trying to go through all of these things so then we will either—we will bring this thing to a head one way or the other. Here [reading]:

The Washington office of the Veterans' Administration photostated the petition, then dispatched two agents to Milwaukee. This pair, instead of questioning patients, doctors, nurses or workers, haled signers of the petition before them, grilled them as to the manner in which they had been led to sign. Sympathetic Legion members, mainly businessmen or local officeholders, were visited by the investigators, quizzed, harassed.

Do you mind giving me some of those names?—A. There is the list of the 110 signers.

Q. Yes, well, that is all right; but who are some of those that will state that the Veterans' Administration sent one or two of their investigators to harass and quiz, harass these people because, you leave the impression that because they signed this petition that they were all intimidated; is that what you want to lead—A. That's—they were.

Q. All of them?—A. Everyone they could get a hold of.

Q. Including "sympathetic Legion members, mainly businessmen or local officeholders." In other words, these men came over here and intimidated and quizzed and harassed these businessmen and Legion officials when General Hines and the Veterans' Administration has leaned backward to please the veterans' hospital—the veterans' organization. That just doesn't make sense.—A. Can I read a letter in there?

Q. Well, identify it, where is it from and who is it from?—A. Well, written by the chairman of the resolutions committee of the Milwaukee County Council of the American Legion.

Q. Give me his name and I will have him come in and testify.—  
A. Maybe he doesn't want his name mentioned now, I don't know.

Q. Well, you have been asking for this congressional investigation for a long time, Mr. May. Maybe he doesn't want his name mentioned. "Signers of the 1941 petition"—A. That is the '41 petition; yes.

Q. (Reads:)

had elected me as their chairman. Nurse Metcalfe warned me that I was "sticking my neck out." Subsequently I was demoted from hospital attendant to common laborer, with the explanation that my transfer was due to my physical and mental conditions. To my protest that I was physically and mentally sound, I was told that an examination would decide the issue. I knew the fate of those enemies of the regime who had yielded to the threat of incarceration among the gibbering lunatics of the mental ward.

Do you care to comment on that?—A. At the time of the Legion national convention here we put out some handbills.

Q. We? Who do you speak of as "we"?—A. A group of employees.

Q. I see.—A. And a meeting—

Q. Well, let us talk about the petition.—A. Well, that is bringing up to the petition.

Q. I see; well, all right.—A. So during that same time some of us met on the 12th of September. We were getting these handbills ready, see, the convention opened about the 16th; the 12th was on a Wednesday.

Q. That is the national convention?—A. Yes. The national convention, and we met with the present Congressman of the district, Wasielewski, at his office on Lincoln Avenue; and he had a stenographer there at the time and we give him quite a number of complaints, and the people was there that was willing to give the complaints. He took all this stuff into Washington.

Q. Complaints similar to what we have been discussing just now?—  
A. Yes, and he took it all back to Washington with him. And then he told us that having a petition made up, that if we would send it in to him he would turn it in to Congress, and that petition was sent down to him and he presented it to the House on October 9, 1941; and shortly after that when the photostatic copies come back and we was taken down into—on the east end which has been turned into a ward now—the personnel office there at that time, and we was taken in before Price, Glassner, and Howe.

Q. To determine the nature of your complaints, or for what reason?—A. Well, they told us, "You tell us what is wrong, and we will take it to Congress and they will take care of it."

Q. How else could they have handled it? I mean they had a responsibility. Did they call you in and ask you to tell them what is wrong and they would present it to Congress?—A. Yes.

Q. And they would try and handle it?—A. Yes; but did Congress get it?

Q. Did you give them the charges?—A. Yes. We told them plenty of things down there but it was taken in individually behind a closed door.

Q. Well, did you want them to do it right out in the open on the lawn; where would you want them to do it?—A. Well, we didn't know they had any authority to, after we petitioned the Congress of the United States, do their own investigating; is that right?



Q. I wouldn't say it is wrong. I would say that they are the authorities at the institution. What was wrong in their calling in these employees and talking to them and determine what was wrong?—A. Why didn't they call us all in at one time, then?

Q. That may have been better; but the fact that they didn't—does that make criminals out of them?—A. Could I read how the questioning was done?

Q. Well, tell me. I don't want you to read. You know; tell me how it was done.—A. They call you down there and they ask you what your name is.

Q. Who are you speaking about?—A. Either Mr. Price or Mr. Howe or Mr. Glassner.

Q. They are investigators: is that correct?—A. They was the Veterans' Administration investigators.

Q. Out of Washington?—A. No; from here. Kennemar and Martin come here later the following year after the resolution was ready to go to the State convention—to the American Legion State convention. That's when Mr. Kennemar and Dr. Martin come here, and they tried to get ahold of different people, and they even called on the officials of the American Legion.

Q. Do you know of anyone who was intimidated, anyone who lost their job, as a result of signing that petition?—A. They can't come right out and lose their job in the way that could be definitely proved; but they was—had the heat put on them.

Q. You have got 400, which is virtually over half of your employees—A. I am talking about the 110.

Q. Or 110.—A. How many is working there out of the 110?

Q. Well, Mr. Weber has been there for 10 years; he didn't lose his job. Name me one person on that 110 list who lost their job because of signing that petition, or one person who was threatened?—A. They didn't come right out and deliberately threaten you.

Q. I mean, what did you do? You left that very definite impression.—A. They threatened me.

O. Oh, just you?—A. Yes.

Q. None of the others?—A. Not as I know of that would admit it right now.

Q. They threatened you, to put you in the "bughouse"?—A. Yes; I had a letter to that effect. I was supposed to go over to the labor gang in the utility department in October, and this wasn't until the following May when they finally got right down to business and insisted that I go over there; and after I worked there a short while I was to be given the mental test and the physical test and the usual procedure to be followed.

Q. Is that unusual—would you say it was unusual under the circumstances?—A. Why should I have a mental test be given to me?

Q. I don't know.—A. That's what I would like to know.

Major FROEMMING. Mr. Domengeaux, may I step in?

Congressman DOMENGEAUX. Yes.

Major FROEMMING. Mr. May was taken out of the hospital as a hospital attendant because he was unable to hold up his end as a hospital attendant, and after some correspondence with our central office it was decided to place him in a position where he could, perhaps, hold up his end on our laboring gang. He interviewed the head of that department, the utility officer, and agreed to come to work. He, how-

ever, failed to report for work. Due to an error, he was paid a half a month's wages which he never earned, and one of our officials is making up that amount of money because Mr. May declined to return it to the fund. Charges were then preferred against Mr. May for being a. w. o. l. from this position of laborer. He had an opportunity to reply to those charges. They were submitted to our central office under civil-service rules, and our central office determined that he was to be relieved; that is how Mr. May left the service of the Veterans' Administration. There was—at no time was there any arrangement or insinuation that he was to be examined mentally or physically. That is determined before a man goes on the job. It was determined that he had the physique to be a laborer and that he did not have the qualifications to be a hospital attendant.

Congressman DOMENGEAUX. Well, Mr. May leaves the impression that those who disagree with the officials there are endangering themselves in that they may be placed into the mental ward in which he quotes:

To my protest that I was physically and mentally sound, I was told that an examination would decide the issue. I knew the fate of those enemies of the regime who had yielded to the threat of incarceration among the gibbering lunatics of the mental ward. I recalled how a prospective victim had fled in a bathrobe at the very door of the examination room—and was never seen again.

Q. Do you know the name of that victim?—A. That was Frank E. Kelly.

Q. Where was he from?—A. I don't know where he was from. He was just a patient up there.

Q. "He fled and was never seen again."—A. Nobody ever seen him around there for a long time. He might have come back later, but I never seen him there all the time I have worked there.

Q. How was he dressed? Did you see him as he fled?—A. Certainly.

Q. How was he dressed? In the regular attendant's?—A. He just had a pair of pants on and an old shirt; they didn't have pajamas in those days.

Q. Well, he was being brought to what—examination room?—A. They asked him a lot of silly questions.

Q. I mean, where is that examination room?—A. Up on the upper floor of the offices there, what they call the second floor, and above that is the bachelor quarters.

Q. You don't know why he was brought there? You were not present when he was questioned, were you?—A. Because he wrote a letter to General Hines.

Q. Do you really believe that?—A. What?

Q. Do you really believe that?—A. Certainly, I believe it.

Q. That they were going to put this man in the crazy ward because he wrote a letter to Dr. Hines?—A. Hines?

Q. General Hines.—A. General Hines.

Q. What was the import of the letter?—A. What?

Q. What did the letter say?—A. He was complaining about the treatment that Dr. Stein gave him.

Q. What kind of treatment?—A. Well, he didn't say what treatment. He was just complaining about the treatment that he got.

Q. You saw that letter?—A. Yes; I saw that letter.

Q. You remember exactly what he said?—A. No; I don't remember exactly what he said; but I know he got a letter back from General

Hines that he would look into the matter, and the rest of the boys started telling the patients; he asked me about it—he said, “Is that true?” “Well,” I said, “if the boys are telling you about it,” I said, “just watch your step.”

Q. The boys was telling him what?—A. The patients in the room.

Q. What were they telling him?—A. They was telling him that “they will have you up before the board. You will be over in 26.”

Q. You want to create the impression that when these people do things that displease the officials that they are put in 26, which is a mental ward. That is the impression you want to create?—A. I am not trying to create the impression.

Q. That is a fact—A. I think there is people who will come up here and state to you those facts.

Q. All right.—A. The man sitting right back there.

MAN IN ROOM. I can swear to that.

THE WITNESS. Just take it easy, Joe.

By Congressman DOMENGEAUX:

Q. Just take it easy, Joe. Who else?—A. Mr. Brand here, who went through quite a session of it.

Q. Who else?—A. Well, you are asking for the hide; we will give you the tail. Ask Mary Loomis to come down here, one of Miss Metcalfe's nurses.

Q. You made the charges. Do you know anybody else besides those two? Are you doctor enough to determine—I don't know what that case is.—A. Maybe there will be some more to come in after they testify.

Q. Are you doctor enough to determine whether their condition will justify that? I mean, you take plenty upon yourself; I don't know what these gentlemen are going to testify to, but I know this gentleman's record. I have one of those that you mentioned from the municipal court, district court of Milwaukee County. One of the cases that you mentioned, this gentleman is going to testify to it. I want to warn him that I have this information and that is one of the cases that you mentioned; and he has been declared incompetent by the courts of this district thoroughly apart and distinct of any activities of the Veterans' Administration, so you take plenty upon yourself when you say that because a man went to the mental ward it was because he interfered, he disagreed with the doctors, or the authorities, and it was not for a bona fide reason. So, we will just continue. [Reading:]

The war against Germany has come to an end. Into Wood now stream younger men, new veterans, recently discharged by the Army. They are new civilians, many suffering from the after effects of wounds or diseases incurred during ordeal by battle. No longer may they receive the skillful aid of Army or Navy physicians. Their future, their lives, are at stake—they are at the mercy of the iron-fisted rulers of Wood.

You are able to—have you been in this war?—A. No.

Q. Have you been in any Army or Navy hospital?—A. No.

Q. Still you can make a comparison that these veterans of this war are no longer under the competent and skillful aid of the Army and Navy physicians but must go into the veterans' facilities at the mercy of these iron-fisted rulers of Wood. Do you think that is a fair statement?—A. Well, after going down to Washington and sitting there on the side lines of the hearings—



Q. No, but that has nothing to do with it, Mr. May. Do you think that that is a proper statement, particularly one who has never went into an Army or Navy hospital? Who doesn't know anything—you don't know whether the Army and Navy is giving competent medical care and assistance to the members of the armed forces. I mean you don't know that.—A. Well, the contention is left that they was according to the reports——

Q. I think they are excellent.—A. They are.

Q. But I don't know and you don't know, and you make a comparison that they come from that fine medical service, at the mercy of the iron-fisted rulers of Wood. You'll hear how patients lack oil and baths to ease bedsores, how they ring in vain for nurses or attendants who are kept busily dusting and polishing, so that on the surface all will seem well. You'll hear, too, of men lying in pools of their own blood or excrement, of tuberculars walking out of the door, of neuro-psychopaths chained or drugged. Can you give me any names——

A. Of patients laying?

Q. Yes, yes. Now, you said, let us start at the beginning. "You'll hear how patients lack oil and baths to ease bedsores." Now, this is my personal observation—bedsores cannot be eliminated because of a congressional investigation. I have gone to the ward where the Parkinsonia cases are. I have seen men who have been in bed for 15 and 16 years, and I have turned them over and looked at their backs, and it is just amazing to me how they are able to give comfort to those patients. I can't see any bedsores, and if there had been, it would not have been a reflection, because they don't know how they can prevent them.—A. They are hard to prevent, yes; that I will agree with you on that.

Q. Yet I turned some of these patients over and they told me. I said, "How do you prevent having bedsores?" They said, "It is because the nurses and doctors and attendants take care of us and are kind to us." Isn't that really the truth, or am I wrong? You may have an isolated case where a man had a bedsore, I don't deny that fact; but don't leave the impression that patients are not given every possible assistance to prevent these bedsores. Do you think they deliberately allow these things to develop?—A. Well, I have heard patients myself ask about little spots on the back, about having them taken care of.

Q. (Reads:)

You hear, too, of men lying in pools of their own blood or excrement.

Now, do you have any such evidence of that?—A. Here is the man I have called for, but he hasn't showed up here yet.

Q. I see; but that—A. I would like to read this into the record.

Q. No; you can furnish it over here if you like, because it is not identified.—A. That is all I have.

Q. Well, keep it then; but it is such a contradiction, because in the last statement, in the next sentence, you state [reading]:

Attendants are kept busily dusting and polishing so that, on the surface, all will seem well.

And then you make the other statement which is such a contradiction that—

Men are left lying in pools of their blood or excrement.

Well, Mr. May, I am satisfied, and I am sure the committee is, that your article was written mostly on hearsay, and that in most instances there is not a semblance of truth to the charges made. Other instances where there is some fact which can—A. May I read a few things?

Q. Just a moment—which can be identified with reference to some of the cases are so discolored, distorted, and misrepresented that they in no way bespeak of the true conditions at Wood. I am satisfied that you have done a great injustice to the American public and to the veterans of this war who are coming back because you have attempted to create the impression that these veterans' hospitals have been utilized in brutalizing patients, in mistreating patients, when, in fact and in truth, there is no foundation, and you have not been able to establish the slightest foundation to any of the statements that you have made.—A. I asked you a minute ago, may I ask you again, if I can read this part here?

Q. Part from where? From whom?—A. Party that was pulled in before Mr. Price on some of the testimony he gave about the conditions?

Q. Conditions about what?—A. At the facility.

Q. Well, I am not interested in that kind of stuff. I mean because like all the others—give me some of your other witnesses.

Mr. MULLIN. Better put on—

Congressman DOMENGEAUX. Let us take this gentleman. I want this gentleman here.

Major FROEMMING. Mr. Domengeaux, could we get the name of the patient that Mr. May claims was allowed to lie in his own blood, and so forth?

Congressman DOMENGEAUX. Can you give me the name of that patient who was allowed to lie in his own blood?

The WITNESS. The name of the patient? Henry Hagen.

Major FROEMMING. H-a-g-e-n or a-n?

The WITNESS. I offered to put it in the record.

Mr. MULLEN. Spell it for him.

The WITNESS. I will spell it, yes. H-e-n-r-y H-a-g-e-n. Ward 4, bed 33.

Major FROEMMING. Have you got a date there?

The WITNESS. The last week in October.

Major FROEMMING. The last week in October 1944?

Mr. MULLEN. What year?

The WITNESS. 1942.

(Witness excused.)

Major FROEMMING. May I ask what are the specific charges?

Mr. MAY. Why should I give it to you now?

Major FROEMMING. Well, we would like to call for the record.

Mr. MAY. I offered for the record there and you didn't accept it, so I am sorry.

Congressman DOMENGEAUX. I would like to have, if Mr. May cares to offer it, photostatic copies of any of these things.

Mr. MULLEN. Don't give up the original if that is all you have.

Mr. MAY. Well, I am trusting him to give it back to me.

Congressman DOMENGEAUX. I will return everything back to you, sir, you have my word for it, and any other papers that you want to give me so that we can make this—so that I can trace down, I will trace them down, you haven't sir.

WILLIS A. BRAND, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your full name?—A. Willis A. Brand. B-r-a-n-d.

Q. Mr. Brand, you have been identified this morning as Mr. A., in an article written by Mr. May, published in the Reader's Scope, in which it is said [reading]:

Mr. A., and X-ray operator, who opposed Nurse Metcalfe, was ordered—under threat of firing—to take a mental examination, was found "insane," then was yanked by a rope around his belly into the county mental hospital, later taken for a ride to the Wisconsin State line, dumped into North Chicago with a warning never to return. Because he had been adjudged insane in the State of Wisconsin, he has never returned to his family who still live in Milwaukee.

Are you the gentleman that is referred to in this?—A. Yes, sir.

Q. Would you care to comment on that, sir?—A. Well, if I may begin from the beginning and give you the facts on the case?

Q. Yes, sir.—A. First, I have been in the Veterans' Administration employ for 20 years.

Q. Yes, sir.—A. I have been in the Milwaukee Hospital, it was the seventh hospital where I worked. When I came to Milwaukee the very first day I started working, an employee came in and began to tell me about conditions at the hospital and frequently during the coming—

Q. Well, now, let us keep ourselves to what you know of your own knowledge, not what someone told you.—A. All right.

Q. Yes, sir.—A. Well, of course, I didn't believe it because the other hospitals where I had been and so far as I had observed were run very nicely, and the things I heard were hard to believe; but I began to observe and I began to get complaints about different things and, in fact, I had gathered considerable evidence and on July 23, 1940, I wrote a letter to General Hines complaining about the conditions at the hospital. I exercised the right guaranteed me under the Constitution.

Q. That is right, sir.—A. And even had I been wrong I was entitled to all the rights that our system of government supposedly gives to all citizens.

Q. That is right.—A. The only reaction to my letter was that I was told that a letter came from Washington that I must appear before a medical board for a mental examination. At first I was not going to submit to the examination but I did, and one of the doctors, who was on the board, told me that there won't anything come of this; but what they will probably do is transfer you to another station. Well, I had moved around the country, I had a family, we had purchased a home and I didn't want to be rooted up again and be transferred to another place. So on account of some reprisals taken against me I went on a hunger strike for 100 hours.

Q. Hunger strike?—A. Yes, sir; as a protest as to that kind of action.

Q. Why didn't you just quit?—A. Why should I quit? I didn't do anything to cause me to strike.

Q. I know but why go on a hunger strike?—A. As a protest.



Q. I see.—A. While I was on this hunger strike two doctors came down to the house and informed me that the charges—

Q. That was at your home?—A. That is right. Two doctors came down and informed me that the charges I made were—would be investigated. I went ahead a little too far. Had General Hines written me stating he had received my letter, or that the charges, that my complaints would be looked into, the matter would have dropped there. The Veterans' Administration had it on me; I was willing to accept responsibility of the charge that I made, and if they were proved to be false, he could of disciplined me or he could of discharged me from the service—preferred charges against me and discharged me from the service. When these gentlemen informed me that an investigation would be made, I let up on the hunger strike, and after I was—

Q. After 100 days?—A. 100 hours.

Q. Oh, 100 hours.—A. 100 hours. When my family physician said I was able to go back to work, I reported back to work. They took further reprisals against me by not allowing me to work. I had started to work but they called me down to the office and refused to let me work after my doctor gave me a statement that I was physically able to carry on my duties. The hospital authorities did not request an examination to determine my ability to perform my duties. So I went home. I just marked time, marked time; in other words, it was what I determined economic pressure being put on me.

Q. Why would these people have it in for you?—A. I didn't say they had it in for me; but I let the facts speak for themselves.

Q. Why wouldn't they let you work?—A. I don't know. I don't know why they wouldn't let me work. I don't know why they took their first reprisals against me.

Q. I see.—A. I finally contacted Mr. Pearsall and he informed me that I had to go to another—

Q. Pearsall was the manager?—A. Yes, sir. For another examination, and I wasn't going to do it, and finally friends of mine urged me to do it and said if you have nothing to be afraid of, why not go down and take the examination. So, in order to try and get the thing straightened out, I went down to Hines for observation.

Q. You mean Illinois?—A. Milwaukee. Hines gave me a clean bill of health. I went to them; they insisted that I go to another place. So I went to the United States Public Health Service hospital.

Q. Who insisted?—A. Pearsall or Washington, I don't know who, but it was the Veterans' Administration. So I went to another hospital.

Q. How do you know that? I mean have you seen orders suggesting these examinations?—A. They told me. Oh, yes; I received a letter after the Hines examination. I received a letter from—I forgot whether it was Dr. Griffith or General Hines—stating that they wanted an examination at still another hospital. I went to another hospital for a period of observation and received a clean bill of health. Then I went back home and then later they sent me, oh, yes, in the meantime, Pearsall—the committee had met with Pearsall, and Pearsall said that I would never go back to work out here at Wood, Wis., if he had anything to do with it.

Q. He was the manager?—A. He was the manager; and I felt, inasmuch as I had not committed any offense of any kind, that I should be reinstated at the Wood Facility. Instead, I was sent down—

I was asked if I would accept a temporary appointment at Hines Hospital. So I went down. I told them I would accept a temporary assignment. They gave me that assignment on my, just, regular straight pay, so I had to go down to Hines, which cost me about \$75 a month out of my salary to live, which I felt was a penalty. Of course, in the meantime, my work was being observed down there as to what kind of work I did, and the report went in with an O. K. on it. But after about 2 months, or 2 months and a half, I was still down there. I decided I wasn't going to accept that penalty any longer, so I went back home and wouldn't report back to the hospital.

Q. You mean in Milwaukee?—A. No; at Hines, where I was working. I came to my home here in Milwaukee. I was just coming back on week ends with the family. Well, things went on. Of course, on account of no income coming in and economic conditions, we faced economic conditions, and I felt that I hadn't done anything wrong, I should not have to suffer any penalty, and they wouldn't reinstate me here. So, after some time, of course, it began to affect my family, and the family physician advised my wife to have me committed.

Q. Family physician?—A. Yes.

Q. Your private doctor?—A. Private doctor. And two other ladies and my wife, understand three had to sign the commitment papers, and their reason for signing the commitment papers was that I had made complaints out here at the hospital and the complaints were not justified, all those two ladies did not know anything about the hospital.

Q. Did your wife know anything about it?—A. Yes. My wife knew what had been going on; she had talked with different people and she had expressed her dissatisfaction. Well, I wouldn't say dissatisfaction, that isn't the word used, but she thought it was shameful the things these people told her. She had spoken with quite a number of them.

Q. Yet she went over and signed the commitment to have you declared incompetent and insane?—A. Well, I was later declared incompetent.

Q. Yes; but she signed the complaint?—A. Yes; on the advice of the physician. Now, this same physician—

Q. On the advice of your family physician?—A. Yes. This same physician shortly after when attending a youngster of some friends of mine told them that he knew I was sane; but he did this in order, on account of my wife's condition. She had become hysterical, etc., due to economic pressure, the long-drawn affair that this is turning out to be. So I was picked up by the police outside of my home as I was going home. No reasons given me whatsoever for being picked up. They took me down to the Johnson Emergency Hospital.

Q. That is a private hospital?

MR. MULLEN. That is one of our county hospitals. A branch of the county hospital.

THE WITNESS. I was taken into a room and told to lie down on the bed, and I was shackled to the bed.

By Congressman DOMENGEAUX:

Q. That is in the county hospital?—A. Yes. They took me in an ambulance out to the County General, where I was finally taken and locked up in the lock ward. About 10 or 12 days afterward a subpoena

was served on me to appear in court. I requested the authorities three different times to contact legal counsel for me—another right which I believe I was entitled to—and they refused on each occasion to contact legal counsel, and later the court sent up an attorney whom I refused to accept. So I was taken into the court and I didn't see an attorney for 5 minutes before I went into hearing, so I had no opportunity to go over anything.

Q. That was in the Federal district—

Mr. MULLEN. Local district court, which is our county court here. Congressman DOMENGEAUX. County court?

Mr. MULLEN. That is right.

By Congressman DOMENGEAUX:

Q. Under the complaints signed by your wife?—A. That is right.

Q. All right. Continue, sir.—A. And I was not allowed the privilege of calling witnesses, and I asked my attorney as to what manner he would represent me, and he said he would ask for a jury trial. And the judge appointed a board of two doctors to examine me. Now, on that board he apparently appointed Dr. Garvey, who had examined me before, made a detrimental report against me.

Q. He was a private physician?—A. He was consultant to the county hospital. Consulting psychiatrist. The attorney asked we be appointed a physician, and that was denied. I was taken to—I was denied a jury trial; I was taken back to the hospital, and on December 24 they asked me to dress to be taken over to the Milwaukee Mental Home. I refused to get dressed, and an attendant gets in back of me, grabs me around the neck, and throws me to the floor.

Q. This is the county?—A. County General.

Q. County General.—A. I didn't raise a hand against him. In fact, it would not have done any good if I could. He was three times my size, he would of floored me with one fist; but, anyhow, they put me on the floor, two or three other attendants picked me up, shackled my ankles and abdomen to the cart.

Q. All of this at the county hospital?—A. Yes; and that's the way they took me to the county mental home. That was the day before Christmas. At the Milwaukee Mental Home I was again taken into court to have an incompetency matter taken up. I was declared incompetent. The attorney at that time asked for a jury trial. I was again denied the jury trial. I was taken back to the hospital and, as I understand, they were waiting for authority from Washington to take me to Downey.

Q. Downey is the veterans' hospital?—A. When they took me to Downey, the Veterans' Administration ambulance—oh, yes, at this hearing one thing I want to bring out. At this hearing Mr. Glassner appeared there representing the Veterans' Administration, and read a hearsay letter stating that I had threatened to kill Mr. Pearsall. Previous to that time Mr. Smalley was sent out to investigate. Before I was committed, before I was picked up at the place Mr. Smalley was sent out here to the veterans' investigator, and he took me into Mr. Pearsall on that very same thing, to tell Mr. Pearsall that I didn't threaten to kill him. I didn't threaten Mr. Pearsall. Someone is supposed to have heard me say it—I don't know—I'd like to kill Pearsall, or some foolish think like that, and Mr. Pearsall said that he was glad that I did not threaten him, and talked for a minute



and in the opinion of Mr. Smalley and myself, and I should think Mr. Pearsall, I should think that would of ended that matter for all time; but at the opportune time Mr. Glassner came down and read that heresay letter in court. I was taken to Downey. I refused to go to Downey. The Veterans' Administration ambulance came over to take me, so I was handcuffed again rather and dragged to the ambulance, and put in the ambulance, taken to Downey.

Q. By the employees of the county hospital?—A. Veterans' Administration. I don't know whether there was a county employee or not, but a Veterans' Administration driver and Veterans' Administration ambulance took me to Downey. I was put in the lock ward and locked up. After about a month I appeared before the staff.

Q. That was at Downey?—A. At Downey.

Q. How did they treat you from the time you went there during that month?—A. They treated me all right; but while in Downey I saw patients being pushed in the face. I saw them kicked, and I saw the attendants take their arms and put them behind their back and twist them, and when a group of patients was taken to the theater after they got in there the attendants said, "All right, you bastards; sit down."

Q. But they treated you all right?—A. They treated me all right. I haven't anything to say against the actual treatment myself outside of keeping me in Downey in a locked ward. I don't think that was all right. And after 30 days I went before the staff. A few days after my appearance before the staff the ward surgeon called me in and said, "We can't find anything wrong with you. You are going to be discharged in a few days." I wasn't discharged, and the ward surgeon said he was going to try to find out what the trouble was. Well, a few days or so he comes in and tells me that the staff wasn't satisfied with my appearance before them because I wouldn't reveal my inner self; and then a little later after that I was called in and asked if I would mind staying on a parole ward.

Q. They asked you that?—A. Yes. They asked me that. I told them I would sooner be discharged. I said if you once discharged me, there isn't anything I could do about it.

Q. Well, you could—A. I don't know what it was.

Q. Didn't they ask you what it was?—A. I told them, "No; I wanted a discharge," but I said, "if you won't discharge me, but I preferred a parole board to that." So in the meantime, of course, my wife had been appointed my guardian. I also wrote her while I was at Downey saying that I wanted a jury trial. She wrote back and said that she was satisfied with the diagnosis made which was made at the county, and the jury trial was out of order.

Q. You had already been adjudged in court?—A. In county.

Q. By the county court?—A. Oh, yes. I forgot one detail. This Board that was appointed by the court, Dr. Garvey called me in himself and the first question he asked me was: "Don't you think you were wrong in making your charge or your complaints against the manager?" In fact practically through all this whole thing, the whole thing centered on Wood and my charges, not about any family matters, but on the charges at Wood; and I told him I would like to have a representative of the American Legion there before I answered any questions, and he dismissed me. Later on I was called in again a couple of days later and Dr. Garvey was there, and the other doctor

appointed by the court. I think it was Dr. Percell, and they asked me a question. I don't know if it was the same question or not, but I gave them the same answer, so I had no examination by the board appointed by the judge. I made my escape from Downey.

Q. Yes, you escaped.—A. Yes. I made my escape from Downey, went down to Chicago and went to work at Downey—or in Chicago. I worked there—

Q. When was that, later?—A. Oh, no; that was after, that was back in April 1942.

Q. I see.—A. See, I was committed in 1941.

Mr. MULLEN. Give him the dates, what are possible, for the record.

The WITNESS. I was picked up in Milwaukee on December 1, 1941. I appeared before the court, the district court, I think it was, December 18, 1941. I appeared for the incompetency charge on December 1, 1941. I was committed to the mental home, Milwaukee Mental Home, on December 24, 1941. I appeared in court for the incompetency charge on January 21, 1942. I was taken to Downey on January 29, 1942. I think I was examined, or I appeared before the staff on March 2, 1942. I made my escape, I think, on April 6, 1942. After working in Chicago a few months—just after I was—shortly after I was declared insane, that's the letter I received from the people I worked for. [Handing letter to the Congressman.] I left there because I wasn't satisfied with the work I was doing. I felt I should be in defense work so I quit there, and went out West because I was afraid in Chicago. Every time I went out in the street I'd look around because I was afraid a cop would pick me up. I went to the Consolidated Vultee Aircraft Corp. I worked there almost 3 years, and here is my service record, where I was promoted up to the position of assistant foreman, 65 people under my supervision whom I trained in war work. This is a form letter which was sent to me when I requested my service record. While in Arizona I gave some volunteer service and this is the letter from the chairman of the—

Q. Office of Price Administration.—A. Office of Price Administration for the voluntary work that I performed.

Q. Very nice.—A. So, in the meantime, of course, I had written, as you are aware, I wrote several letters in the past 2 or 3 years to Mr. Hines.

Q. Yes.—A. This thing is still hanging over me. My guardian has made no effort to have this stigma removed from me which I think was unfair from its beginning. So I came back to carry out the pledge which was in—

Q. That is the situation as it is now?—A. No. I went to the hospital and saw—

Q. Which hospital?—A. Veterans' hospital.

Q. At Wood?—A. At Wood. Saw Colonel Mullins and saw Colonel Bresnahan.

Q. When was that?—A. On July 4.

Q. This year?—A. Yes, sir. I told them what I was there for and they informed me that as far as the Veterans' Administration was concerned, I was—that stigma didn't hang over me any more. I was considered to be sane. I had been out of the hospital for a couple of years, and Dr. Bresnahan suggested that there probably would be a better way of going about this thing. He said, "I just don't know what the situation is." So he took me down to the attorney and introduced

me to the attorney; and in the meantime before that Dr. Bresnahan and Dr. Mullins had told me that they would do anything they could to see that I got cleared of this thing. So Dr. Bresnahan took me to the attorney and informed him of that, and wanted the attorney to make some suggestions what I should do. Well, he looked me up and found out that my commitment had been to the county hospital. If it had been to the veterans' hospital there wasn't anything more to it. I was a free man; but the commitment being in the county hospital I'd have to get an attorney and have that discharged. I did. I engaged Mr. Mullen, and I have petitioned the court to—for reexamination and to discharge this diagnosis. I was down there last Wednesday, both doctors—two doctors appointed by the court examined me and declared me sane. Then my wife's attorney presented some of those letters that I had written and her attorney had asked for a postponement.

Q. That is the situation?—A. That is the situation as it stands now. But there is one thing I would like to ask.

Q. Yes, sir.—A. In view of the fact of what Colonel Mullins and Colonel Bresnahan told me, why did the attorney from the Veterans' Administration go down to court and tell them that I was bothering them out at the hospital again when they informed me that they would do all they could?

Q. That was in the original trial?—A. No; just this past week, after I had talked to Colonel Bresnahan and Colonel Mullins on the 4th of July, and then what they had told me what they would do. The Veterans' Administration wasn't interested in me, that I was clear as far as they were concerned, and took me down to the attorney, and then why did the attorney from the Veterans' Administration go down to court and tell them that I was out to the hospital bothering them? I have information to that effect.

Q. Well, is that your testimony?—A. So far.

Q. Well, now, I am trying to reconcile what you have said and I have no comments to make about—and I have no jurisdiction to determine those personal matters that have arisen in your case, through the county courts; but what I was interested in were the charges made against the Veterans' Administration in this article in which it was said [reading]:

Was found "insane," then was yanked by a rope around his belly into the county mental hospital, later taken for a ride to the Wisconsin State line, dumped into north Chicago with a warning never to return. Because he had been adjudged insane in the State of Wisconsin.

Your testimony doesn't—A. Well, it didn't happen just exactly like that but it was just as bad.

Q. But that was done by the county officials?—A. Yes; but the Veterans' Administration took me from the county down to Downey in the Veterans' Administration ambulance, from the county hospital to the Downey.

Q. At the request of the county officials?—A. I suppose; yes.

Q. The records of this case taken from the official records of the—A. Must my records be revealed here?

Q. They are public records. If you object to—A. You mean public to the extent that they must be reviewed before anyone at all without my permission?

Q. Well, I will respect your wishes. A. I'd be glad to go into the record with you in private.



Q. Well, I will respect your wishes.—A. Because I know there is a lot of lies in the record.

Q. I think that certainly in view of these charges that they should be disclosed because all this has been made public. Your complaints, if I understand them correctly, arose with differences that you had at the hospital?—A. No; no difference—I didn't make any complaints about any differences. I had one or two personal matters I took up; but I didn't make, I never yet have brought up one of my complaints in any court at any hearing except unless I was asked specifically by—

Q. But what I want to know, "To my personal knowledge," Mr. May said, which is you.—A. Yes, sir.

Q. (Reads:)

an X-ray operator, who opposed Nurse Metcalfe—

A. Well, I must correct that. I didn't oppose Miss Metcalfe.

Q. You had no differences?—A. With all due respect to Miss Metcalfe, although in making my complaint I did mention Miss Metcalfe as one of the patients, but Miss Metcalfe had nothing to do with my department and I don't ever recall having any differences with her directly or opposing her, or her opposing me.

Q. (Reads:)

was ordered to take a mental examination, was found "insane."

Now, these activities were done by the county court. You were found insane by the county court. Then:

was dragged by a rope around his belly into the county mental hospital.

Your testimony given on direct examination doesn't state that.—A. Well, I was shackled around my ankles, my wrists were shackled, and my abdomen was strapped.

Q. By the county?—A. By the county.

Q. By the county officials?—A. That is right.

Q. Of which the Veterans' Administration had absolutely nothing to do with?—A. Well, I never stated that.

Q. No. I am trying to get Mr. May straight on this. This is what Mr. May stated [reading]:

and was yanked by a rope around his belly into the county mental hospital, later taken for a ride to the Wisconsin State line.

A. Of course, if the Veterans' Administration had never taken the reprisals, and so forth, and put the pressure on me, of course, then those things would never have happened. They were indirectly responsible for what happened.

Q. Well, the records indicate, Mr. Brand, that these charges were brought by your wife; the complaint was instituted—A. That is right; on the advice of my attorney—or my family physician.

Q. Of your family physician.—A. But what did the Veterans' Administration, what business did they have entering into it? What business did Pearsall have sending a man down, an attorney down there reading a letter about me threatening to kill people when it was all a falsified story? There isn't an iota of truth in it. In fact, there is a statement in it by one of the doctor, I later found out, who also stated I threatened two other doctors; this doctor also states that he never knows of me threatening—

Q. Judge Harvey Neelen?—

Mr. MULLEN. N-e-e-l-e-n; he is the county judge of the district court, and that is one of our courts of commitment.

By Congressman DOMENGEAUX:

Q. Before which your case came has stated to me that the Veterans' Administration had absolutely nothing to do with these activities.—A. Well, why is it that they continually harped on the Veterans' Administration problems? When I was called in by Dr. Garvey, he was appointed by the court for the second examination, that was the first question he asked me. Why is it down here when I was down here just for the hearing here last week that those were the questions he asked me, if I was going to continue this fighting and going on with this thing now that I am back here? See, I have been away from here for over 3 years and I haven't had any—

Q. That may have been the origin of your trouble and the psychiatrist, their examinations may determine that those are proper questions. But the point is this: That the Veterans' Administration, and you admit it, had nothing to do with you being extradited; that was done in the county court. That these brutalities of being tied by chains and other things took place in county hospitals?—A. That is right.

Q. And that the veterans' hospital had not mistreated you. You stated that, did you not?—A. That the Veterans' Administration had mistreated me?

Q. Had not mistreated you?—A. Yes, while I was a patient in the hospital.

Q. That is all I am interested in. I am not trying to investigate your particular trouble and I am respecting your wishes by not divulging any of this; that is correct, isn't it?

Mr. MULLEN. That is all right.

By Congressman DOMENGEAUX:

Q. I was only interested in knowing the connections of the Veterans' Administration. I am satisfied that this has been a county matter of which the Veterans' Administration did not participate in under your own testimony.—A. But they did participate in it by appearing in court, and they participated again last week when the attorney—

Q. You don't know whether or not they had been called in by the court so as to give whatever knowledge they may have at their disposal?—A. As far as I know the men went down there voluntarily and said that I was bothering them. I wasn't bothering them. I had been out to the hospital that one day.

Q. Those are incidental matters. The charges on the statement are what I am interested in, and under your own testimony, by and large, the Veterans' Administration had little to do with your present trouble.—A. Can I ask the attorney why the attorney did that after Colonel Mullins and Colonel Bresnahan, if—

Q. I have no objection.—A. If they can answer the question for me, or Mr. Howe can answer it.

Mr. C. W. HOWE. As I understand it, Mr. Brand, you came out to the Veterans' Administration—

The WITNESS. Two—

Mr. HOWE. And asked whether there was any cooperation we could extend to you as to having your guardianship lifted.

The WITNESS. No. Dr. Bresnahan took me down and introduced me and asked Mr. Dorey—

Mr. HOWE. And Mr. Dorey, the attorney, examined the records in the district court and the county court to ascertain what your status was, and that was the purpose of his trip, nothing else.

The WITNESS. Why did he make that remark?

Mr. HOWE. No remark—there was no hearing scheduled at that time; he merely went there to examine the records.

The WITNESS. That is right; but why did he make that remark that he made that I was bothering you out at the hospital again?

Mr. HOWE. I don't know anything about that.

By Congressman DOMENGEAUX:

Q. Well, thank you very much. I will respect your wishes and not go into anything further. I am only interested to know the connections of the Veterans' Administration in the alleged brutality that they imposed upon you, and I find no evidence of that under your own testimony.—A. I wish to add at the time I made these complaints, I don't know how many statements I had. I had about 30 people who were going to testify in court or testify in an investigation; I had about 20 written statements by people about the charges that I had brought up.

Q. That was before or after you were declared incompetent?—A. Before that was when I made—when I wrote my letter of complaint. I wrote the parties—some of them were already out of town—I wrote those parties and in the letter I asked for any information that they would want to give me of their own free will and accord about the treatment they received would be welcome. No one was urged or highjacked to give me information. At the time, if they had wanted me to prove my charges, I had ample testimony to prove it and I had investigated it from every angle that I possibly could.

Q. I see. Thank you, sir.

(Witness excused.)

Mr. MULLEN. Come up here [speaking to Mrs. Weber].

Congressman DOMENGEAUX. Can you explain it? I have heard that there is a meal on the night shift of those employees from 11 to 7—

Mr. MULLEN. There is no meal provision made for that.

Congressman DOMENGEAUX. What time?

Mrs. WEBER. The last meal for those people that have to go on at 11 o'clock is at 10:30; they have to eat at 10:30; they have to eat on their own time.

Congressman DOMENGEAUX. These employees who must go to work at 11 o'clock, there is a deduction for their meals and they are required to come at 10:30 to get their meals; is that correct?

Major FROEMMING. Well, there is a meal served right around 11 o'clock. I would like to have Miss Metcalfe explain that—who assigns those people, and would know exactly when those meals are served?

Congressman DOMENGEAUX. Will you give some explanation on that?

Miss METCALFE. Since they work straight 8 hours there is no meal-time during that 11 p. m. to 7 a. m. shift. They eat their meal before they go on and it is served at 10:30 or until 11—any time between 10:30 and 11 if they want to eat; or it depends upon how much they want to eat.

Congressman DOMENGEAUX. But they are deducted.



Miss METCALFE. Well, I guess so. That, of course, is not our regulation; I think that is central office.

Congressman DOMENGEAUX. Well, I am not placing the responsibility but it looks very unfair to me that these people who come to work at 11 o'clock, and their meals are deducted, must come there at 10:30 in which to get their meals. That looks like a very unfair imposition against these employees. It looks that way to me. I can't understand why an employee's meals would be deducted when the probability is because of the type of work, I mean the nature of his hours, that he will not be able to take advantage of those meals served when he first comes on to work. I am not—probably central office regulations, but it is a regulation that should not be in effect in my opinion because that employee should not be forced, when he is paid only for 8 hours a day, to come in at 10:30 to get his meal which would mean that he would have to rush to get that meal.

Miss METCALFE. They have the choice of eating their breakfast after they get off duty in the morning or the night meal before they go on. They don't have to eat the night meal, they have to eat one meal and they have their breakfast when they get off at 7, and many of them do take that instead of the supper; many of them take the morning meal.

Congressman DOMENGEAUX. The morning meal instead of the night meal?

Major FROEMMING. The rule is the food handler takes one meal during his term of duty, and they work exactly 8 hours at night, from 11 to 7, and our day employees, now, they work 8½ hours which includes a half-hour luncheon period so the mealtime is on the employee's time. And these 11 to 7 employees have the privilege of taking their meal either prior to going on duty before 11 o'clock or subsequent to 7 in the morning.

Mr. MULLEN. But it is not in the middle—

Congressman DOMENGEAUX. There is no provision made for the middle of the workday, that is the purpose, say 2 o'clock in the morning?

Mr. MULLEN. Yes, those that live away from there—they don't need to come. They charge for it, \$90 a year off the income tax, so it means in reality it is a deduction of their pay, and their wages. I merely mention it when you seek to make a correction by giving us some consideration.

Congressman DOMENGEAUX. \$90 a month?

Mr. MULLEN. \$90 a year comes off of there plus the State tax and the Federal tax. See, we have both here. It means a deduction of salary.

Congressman DOMENGEAUX. This is not under your department; employees are charged on income for the deduction of their meals under the internal-revenue regulation?

Major FROEMMING. Not that I know of.

Mr. MULLEN. That is the law whether they know about it or not. Forgive me for being so rough about it, but that is the law. That is part of your salary and our court has so construed it here, and the Treasury has so construed sustenance, laundry, board and room, or anything that is considered the value of that is added to your income to arrive at your tax. Your tax comes off the top. Now, that is the situation here.

Congressman DOMENGEAUX. That is true as to all taxpayers.

Mr. MULLEN. That is right.

Congressman DOMENGEAUX. I mean it applies to all taxpayers. You are allowed a deduction and under that deduction or under the theory it is that the part of those living expenses is why that deduction—I don't mean deduction——

Mr. MULLEN. Salary.

Congressman DOMENGEAUX. Yes.

Mr. MULLEN. That is right; but here these men lose that \$90 a year that they don't get the meal anyway because it is inconvenient to have, and I can see rightfully they should not have a kitchen running 24 hours a day. I can see that, too, but because the facilities are not there for them to take that meal I think it is an unjust regulation to force them to pay for it. That is the part I mean because it amounts to a deduction which makes it over \$100 a year, which is coming off of their basic salary. They are not at fault here, understand, but I thought inasmuch as you are going into these——

Congressman DOMENGEAUX. Well, I think it is necessary to say employees——

Mr. MULLEN. That is right. That is for the purpose of bringing up the matter here.

Congressman DOMENGEAUX. For the purpose of building up the morale of an institution.

Mr. MULLEN. That is right.

Congressman DOMENGEAUX. Because if your employees are satisfied I think, largely, your patients get better service. The employees necessarily in this investigation come second, the patients' consideration is the first——

Mr. MULLEN. That is right.

Congressman DOMENGEAUX. Consideration. Under the regulation employees have got to—the meals are deducted; they have no option of taking meals or not taking meals; is that correct?

Major FROEMMING. All food handlers have the privilege of taking one, two, or three meals at the facility. Most of those who live outside of the facility take one meal, and food handler must take at least one meal during each tour of duty; and a very substantial meal is made available for him during that time.

Mr. MULLEN. Well, the food handler was arbitrarily determined to include almost anybody whether they handled food or not. There was an arbitrational determination by the central office.

Major FROEMMING. The food handler is only inclusive of the mess attendants and the hospital attendants, both of which groups handle food. They are in the presence of food and they serve food and are considered as food handlers.

Congressman DOMENGEAUX. Other employees don't have to, just food handlers?

Major FROEMMING. Just food handlers.

Mrs. WEBER. Now, those people that work from 11 to 7 in the morning, there is no meals served at that time, at the time they are there. How did they get to be food handlers? Because there is no meals served through that time.

Mr. MULLEN. This attendant is not a food handler because he handles none, that is, the attendant from 11 to 7 doesn't need—he doesn't handle any food.

Mrs. WEBER. There is no meal served at that time, so how could he be a food handler?

Mr. MULLEN. The other two shifts do handle meals because they carry it to the patients; but the question here is that the 11 to 7 do not handle food so to include them is an arbitrary designation of them as food handlers, when, in fact, they do not handle food. I believe I have seen a regulation which I felt was very arbitrary—

Congressman DOMENGEAUX. Let me get this straight. Just those who handle food are forced to take one, two, or three meals under the regulations?

Major FROEMMING. That is right.

Congressman DOMENGEAUX. Those who don't handle food need not take any meals at all; is that correct?

Major FROEMMING. That is right. Of course, our attendants are subject to being shifted from one shift to another. We have three shifts. We function the hospital 24 hours around the clock, and it would be very difficult from the standpoint of maintaining records and making the productions to isolate some groups. It is true that certain attendants working the night shifts, like Mr. Weber and several others of our older attendants that prefer night shift, are on more or less continuously with us.

Congressman DOMENGEAUX. Are the deductions made, Mr. Weber?

Mr. WEBER. Yes, sir.

Congressman DOMENGEAUX. How long have you been working at night?

Mr. WEBER. About 7 years.

Congressman DOMENGEAUX. That is a long time.

Mr. MULLEN. Continuous.

Congressman DOMENGEAUX. And you have been against your wishes—

Mrs. WEBER. He had to pay me for meals but he liked—

Congressman DOMENGEAUX. You pay for meals even though you have been working for 7 years, and you are not a food-handler?

Mr. WEBER. There is no food to handle now, hardly.

Congressman DOMENGEAUX. How can that be explained?

Major FROEMMING. Well, he is one of the attendants that ordinarily is subject to being changed from one shift to another. Now, the rules are that all hospital attendants, irrespective of the shifts they are on, are subject to taking the meal and the meal is then prepared for them.

Congressman DOMENGEAUX. Then the rule doesn't mean anything when you exclude it to food handlers because all the others are put in the same category. There is a man who has been working for 7 years on a night shift where he doesn't handle food.

Major FROEMMING. Well, in his case we made an exception to the rule rotation to permit him to work at night because he liked the night work.

Congressman DOMENGEAUX. But then his deductions should not have been made in keeping with that regulation.

Major FROEMMING. Well, the rule that I am mentioning is laid down to us by central office and includes the shift from 11 to 7.

Congressman DOMENGEAUX. Looks like a very arbitrary rule.

Major FROEMMING. I can see the angle that is brought out here is a reasonable angle from their point. However, basically when the attendant takes this position, the position as hospital attendant or ward



attendant, the conditions under which he is to work are brought to his attention and he accepts them, and they become part of the contract of employment.

Congressman DOMENGEAUX. I can understand that, too; they have very little discretion in the matter but, therefore, under the—not under the interpretation of the regulation but under the practice that prevails every lay employee there is charged for at least one meal when the vast majority of them are not food handlers; isn't that correct, sir?

Major FROEMMING. Well, the vast majority are food handlers because they serve during a period when food is actually handled, and the night shift is comparatively light between 11 to 7.

Congressman DOMENGEAUX. Well, the regulations ought to be changed for the people who are not food handlers, ought to be given that relief, I think.

Mr. MULLEN. See, that amounts to about ninety dollars-plus every year for the privilege of working 11 to 7; that is what it amounts to. I mean it is a penalty imposed; that is the practical effect of it.

Major FROEMMING. I can see the standpoint here; I can appreciate the attitude.

Congressman DOMENGEAUX. I can see where an individual would be very much dissatisfied when he is not a food handler, and he is charged this deduction. That is a central office regulation. I know all those things flow from central office; but they ought to change that regulation, or they ought to change that policy.

Major FROEMMING. Of course, it is within the realm of possibility for a person to adjust his personal habits if he works regularly between 11 and 7, so that he could take either a meal just prior to 11 o'clock at night, or immediately subsequent to 7.

Congressman DOMENGEAUX. Well, we don't want to regiment people in the American way of life, American form of government, that we are going to tell them every activity of their existence. I mean people are entitled to those leeways.

Major FROEMMING. The point that I am trying to make is that it was consistent to live under those conditions without jeopardizing your health.

Congressman DOMENGEAUX. Yes; I think that is so, but I don't—that is a matter of personal choice, and we shouldn't try and dictate to people how they should live or not live; and I am not suggesting that anyone is; but people have got the right to determine their own habits, if they are in keeping with the requirements of their employment.

Is your testimony along that same line?

Mrs. WEBER. I work there as a mess attendant.

AGATHA WEBER, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. Give me your full name, please.—A. Agatha Weber. I work there in 1943 as a mess attendant, and while I am working there I noticed quite a few things that I didn't approve of; and I couldn't eat the meals that they were prepared over there.

Q. When was that, ma'am?—A. Oh, that was as soon as I started working.

Mr. MULLEN. Identify the year.

The WITNESS. 1943.

By Congressman DOMENGEAUX:

Q. 1943?—A. Yes. I start in May, worked until December.

Q. You are not working there any more?—A. No.

Q. Why did you sever your relations with them?—A. I couldn't eat the food that they prepared.

Q. So you quit?—A. Yes. I was losing too much weight. A couple of times I took my sandwiches along but it didn't work either.

Q. What was the matter with the food? It was not served properly?—A. No. For one reason I saw too many cockroaches.

Q. You saw too many cockroaches?—A. Yes; and then I noticed that all the bread that was left over on the tables, at that time they used to serve family style, that all the bread that was left over on the table they would put in one big can and it would stand there overnight and the cockroaches had a lot of time to dance over that bread. And then in the morning as they need that bread in the kitchen they would dump all that in that machine where they ground that bread up with everything, and that would be used up for bread dressing or bread crumbs, whatever it was needed for, and that I didn't approve of.

Q. That doesn't happen in the best regulated homes some times?—A. I don't think so; and then another thing I saw one of the cooks mixing meat for meatloaf. He was leaning over a big bowl of meat mixing it, and it was hot in the summertime, and sweat was dripping right in there.

Q. Did you call that to the attention of the supervisor?—A. That wasn't my duty to do that. I was only a mess attendant but I happened to notice those things.

Q. Do you know whether the authorities condone and approve that?—A. I wouldn't know about that because I don't think they know it.

Q. You don't think they know it?—A. I don't think they noticed, but I noticed.

Q. Oh, I can see where that could happen but that was not the usual thing, was it?—A. Well, there was a lot of little things that I didn't approve of, and that spoiled my appetite. I told my husband about it and he couldn't eat either, so I have to cook home for myself so I think it is much better if he eats at home. He likes my cooking much better, anyway he says so.

Q. I am sure he does. Yes, I am sure he does. Anything else, madam?—A. That is all.

(Witness excused.)

Major FROEMMING. Mr. Domengeaux, may I say in connection with the testimony of Mrs. Weber, she is the wife of Mr. Weber. She worked for us for a short period of time, and resigned because she was not satisfied with her efficiency rating, which was "good" under our system of rating efficiency. The conditions that Mr. Weber has described are not condoned in our kitchens, or dining rooms.

Congressman DOMENGEAUX. Well, I am sure—

Major FROEMMING. Our hospital kitchens are under the control of seven dietitians who are professional people. In that respect, they, themselves, eat the food that is served and prepared there, and I know

that they would not tolerate conditions of that kind, just speaking in general terms.

Congressman DOMENGEAUX. Well, I am satisfied of that.

Mr. WEBER. Mr. Domengeaux, I would like to correct Mr. Froemming's statement. Something he failed to mention when we were hired. We have, we are asked to sign certain papers. We are not asked if you want to sign them or not, we are just told to sign them, or if we don't sign them we don't get the job.

Congressman DOMENGEAUX. I don't follow you. What kind of papers, and "don't get what job"?

Mr. WEBER. Any job. At the Veterans' Administration they have those rules and regulations all in them papers, and they don't ask anyone whether he wants to take meals or not. They just ask him to sign.

Congressman DOMENGEAUX. Oh, on the meal proposition?

Mr. WEBER. Yes.

Congressman DOMENGEAUX. Well, we have thrashed that out and we understand the meal situation; but you have been signing whatever papers you want and others that you have not wanted, and you have worked for 10 years and they haven't fired you.

Mr. WEBER. I I wanted a job real bad I will sign the papers or I don't get the job; that's the idea. I have no choice.

Congressman DOMENGEAUX. What papers are you to sign?

Mr. WEBER. Well, maybe Mr. Froemming could explain that better.

Congressman DOMENGEAUX. No, you.

Mr. WEBER. We all sign papers with rules and regulations. Me and my wife went to see Mr. Froemming 2 years or so ago.

Congressman DOMENGEAUX. You mean when you first went to work there?

Mr. WEBER. No, about 2 years ago, that was right after this meal tickets were withheld from me and Mr. Froemming said that, "You know dam well you signed for it. You know the rules and regulations." Sure, we know the rules and regulations but one has no choice. You either sign or you don't get the job.

Congressman DOMENGEAUX. Well, now——

Mr. WEBER. Do I make myself clear?

Congressman DOMENGEAUX. No, sir. I wish you would explain it. You are talking about when you first became connected with the Veterans' Administration?

Mr. WEBER. Yes.

Congressman DOMENGEAUX. What other papers did you have to sign?

Mr. WEBER. I don't know what they call it. It is a contract or something.

Congressman DOMENGEAUX. Well, don't you sign a contract when you join the union to live by its rules and regulations?

Mr. WEBER. Yes, sir.

Congressman DOMENGEAUX. Don't you sign a contract between unions and capital by which they are going to agree to certain conditions?

Mr. WEBER. Yes, sir.

Congressman DOMENGEAUX. That is a voluntary agreement.

Mr. MULLEN. That is what the Veterans' Bureau says [showing to Congressman].



Congressman DOMENGEAUX. What do you want?

Mr. MULLEN. Nothing. I am just trying to tell you about it, that is all.

Congressman DOMENGEAUX. Well?

Mr. MULLEN. I mean our complaint is as I have said it all before, and what this is, it is just accumulating—I am satisfied.

Congressman DOMENGEAUX. Mr. Weber, I don't quite understand yet and I want you to give me any specific instances where you were forced to sign something, and that if you didn't you would lose your job.

Mr. WEBER. I wouldn't get the job.

Congressman DOMENGEAUX. Oh, you wouldn't get the job.

Mr. WEBER. I wouldn't get it in the first place.

Congressman DOMENGEAUX. Oh, I see. Well, in other words, when you get that job you agree to a contract of employment?

Mr. WEBER. Yes, sir.

Congressman DOMENGEAUX. Is that correct?

Mr. WEBER. That is correct.

Congressman DOMENGEAUX. If you don't sign it, you don't get the job?

Mr. WEBER. That is it.

Congressman DOMENGEAUX. What is wrong with that?

Mr. WEBER. What is wrong with that? I am a married man. I eat at home and those meals, at first when I first was made to pay for three meals, and I didn't eat any more than I eat, and I haven't eaten a meal for 2 years.

Congressman DOMENGEAUX. Well, you heard my expressions about that. I am just wondering whether it isn't good business practice, I mean in an organization as large as the Veterans' Administration, that when an employee becomes engaged by the Veterans' Administration at an understanding, a contract be entered and signed before the employment is taken over. That is not necessarily bad business practice. In your case it has worked, and I don't think that you should be charged for your meals if you are a nonfood handler, that you have been working in that capacity for 7 years and under the regulations those who don't handle food are not to be charged, and still you are charged. I don't think that is right.

Mr. WEBER. And furthermore, if I should be forced to take meals or anybody I know there are people who like to eat—

Congressman DOMENGEAUX. We have agreed on that. I agree with you absolutely on that, Mr. Weber. Under the regulations, as I understand it, those who don't handle food are not to be charged and still you are being charged even though you have been on that job for 7 years. I think that is a very arbitrary interpretation of the law. That is my personal opinion.

Major FROEMMING. Mr. Domengeaux, I recall having an interview with Mr. and Mrs. Weber several years ago and discussing this meal business with them; and I explained the regulations under which we operate but I do deny that I used the word "damn" or other such forceful language.

Congressman DOMENGEAUX. I am disappointed in you for not using "damn" once in awhile. That doesn't make a man irreligious, in my opinion. But still, under the regulations, I don't see how you

can justify charging this man his meals because he is a nonservice handler and has been in that capacity for 7 years. Now, you can possibly justify as to those who change from one department to another. I don't see how that can be justified under the regulation. That is my personal opinion. I am not running the hospital. Any-one else care to testify?

Mr. MULLEN. Are you ready now? Come up here.

(Gentleman talking to Mr. Mullen.)

Congressman DOMENGEAUX. You are perfectly at liberty to say whatever you like, sir.

GENTLEMAN IN ROOM. Yes, I know; but she wants to take different steps.

Mr. MULLEN. You mean legal steps?

GENTLEMAN IN ROOM. Yes; take it to legal steps.

Congressman DOMENGEAUX. I don't know what you are talking about.

Mr. MULLEN. Do you want that in the record then?

Congressman DOMENGEAUX. Take it off the record, if it has no significance; we don't even know the witness' name. Anybody else?

Mr. MULLEN. Mr. May, who else have you got in this?

Mr. MAY. This man [indicating].

Congressman DOMENGEAUX. Oh, you are the one. Just sit up here.

JOSEPH BRUNE, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Mr. MULLEN. Give your full name now to the reporter.

The WITNESS. Joseph Brune, B-r-u-n-e.

By Congressman DOMENGEAUX:

Q. Are you an employee of the hospital?—A. No, sir.

Q. You were?—A. Yes, sir.

Q. How long did you work there, sir?—A. Well, about 5 years, I think. I left there July the 2d.

Q. Yes, sir.

Mr. MULLEN. Of this year?

The WITNESS. Yes.

Mr. MULLEN. Call off the years to the reporter because when the Congressman rereads this, dates won't make any sense to him if it doesn't give the year.

The WITNESS. This pertains to myself. Under the conditions up here at the sleeping quarters we have 14 men in one room.

By Congressman DOMENGEAUX:

Q. Is that the domiciliary?—A. It is a large room.

Q. In the home?—A. No. It is in the sleeping quarters for the help there that stay on.

Q. Well, now, excuse me, sir, you are not—are you living in the quarters?—A. I was.

Q. Oh, I see. As an employee?—A. Yes, sir.

Q. Not as a veteran?—A. No, sir.

Q. I see.—A. And among those 14 there were all 3 shifts, day shift, the 2:30 to 11 shift, and the 11 to 7 shift, and you couldn't get hardly any sleep. The men were coming in and out all during the hours of the day and night.

Q. Pardon me, sir. The hospital was requiring that you stay?—  
A. Well, they don't; well, they did there for a while require you to stay on the grounds but they don't at the present time.

Q. Purely as an employee?—A. That is right.

Q. The only capacity at that time was as an employee?—A. That is right.

Q. And you were living on the grounds?—A. That is right.

Q. In quarters furnished for the employees?—A. That's right. Well, I couldn't get any sleep so I had been rather restless. I took a couple of sleeping tablets and I had been unconscious from Monday afternoon until Wednesday evening. Someone finally got an O. D. to examine me and couldn't arouse me. He sent for home guards, dragged me down the stairs from the second floor, hauled me to No. 2 annex in a car and then to 26 in a wheelchair. .

Q. Who did that?—A. The guards, the home guards.

Q. Who?—A. They are home members.

Q. Home members?—A. That is right.

Q. Soldiers who were there in the domiciliary home?—A. That is right.

Q. You don't know of the particular one?—A. Well, I don't myself but I have a fellow that saw the whole procedure. I was unconscious, I didn't know anything about it myself. They gave me several hypos, different variety, so I understand, and still unconscious they shot strychnine into me.

Q. Well, now you were unconscious?—A. That is right.

Q. How do you know it was strychnine?—A. Well, I had talked to the O. D. that happened to be on at that time; about 2 or 3 days later he came up to see me and told me the story. I will give you his name. So he said that I had very little heart beat, hardly any pulse and respiration. I don't know how many hours it took them to bring me to but it was several hours, plus three doctors.

Q. You had a heart attack?—A. No; it wasn't a heart attack. It was from the sleeping pills I had taken. It was the first time I had ever taken them in my life. I think Dr. Meyst was the O. D., that night that took care of me. He told me afterward that the strychnine shot was the last hope. I asked him when I came to who gave the orders to send me to 26. That is, I asked Major Liberman, and he is the head doctor of 26.

Q. Had you had any previous trouble with any authorities or anything?—A. No, sir.

Q. You had no trouble at all?—A. No, sir. And he told me that those orders came from Colonel Mullins. Now, Colonel Mullins, I don't see how Colonel Mullins could give orders to send me to 26 under those circumstances because he didn't know anything about the case in the first place. But those words came from Major Liberman.

Q. If I understand you correctly, you stated just now that after you were unconscious that this guard, the domiciliary member, dragged you down the stairs and brought you to 26?—A. That is right.

Q. He brought you when he discovered you unconscious and brought you there?—A. The O. D., gave orders.

Q. Oh, I see.—A. Now, after being in 26 for 2 days I had recovered enough to get on my feet. Major Liberman at once wanted to transfer me to another ward. I refused to be transferred.



Q. You wanted to stay in 26?—A. I says I was put in 26 and I'll take the rap and stay here.

Q. You refused to be transferred?—A. That is right. I stayed in there for 14 days I think. Every day the doctors would want to discharge me. Well, I had information got up to me from a very good friend that I was going to be discharged, and that when getting out—

Q. You mean discharged out of the hospital as a patient or discharged as an employee?—A. That is right.

Q. I see.—A. So he says the first thing is to go over and hand in your resignation which I did on July the 2d. It was discharged on July the 2d.

Q. Anyone ask you to do it—just under the advice of this friend?—

A. That is right, and I then tried to find out how much good time I had of sick leave, and so forth. And was told to go down to the personnel department which I did. The personnel department I asked them how many—how much good time I had coming. They told me that they had given the figures to Miss Metcalfe which proves that I was all lined up for the gate because they had—

Q. How did that—A. Because they had the figures right down there, the papers and everything were right down there on her desk.

Q. After you had resigned?—A. That was only 5 minutes, they couldn't of got them down there that soon. Now, I wanted to find out why I was dragged down those steps after that doctor knew that I was unconscious, why I was dragged down those steps, throwed in a car and brought to 26, a mental ward. If I had been a mental he certainly wouldn't of wanted to discharge me out of that ward inside of 2 or 3 days.

Q. Now, when you say "dragged down," you know that only from—you were unconscious?—A. The employees up in the building saw the whole procedure.

Q. You mean they just dragged you without a stretcher?—A. No, sir; they got me one under each arm and dragged me right down those steps. They never hauled me over there in no ambulance, no stretcher. They never brought me in the ward on a stretcher.

Q. That was domiciliary inmates who did that?—A. That is right.

Q. Have you got—do you want the official record to indicate this?—

A. The official records?

Q. I mean the records of the hospital.—A. I don't want any records brought out here. These men, I think Dr. Bresnahan should know something about this case. I think he can tell you about it, if that is a fact or not.

Q. Do you know anything about the case, Doctor?

Lieutenant Colonel BRESNAHAN. Yes. I remember his case, and I would like to read his hospital record because he was a patient under treatment. If he will give me permission I would like to read it, summing up.

By Congressman DOMENGEAUX:

Q. Well, you want to know, my friend.—A. Say listen, Congressman.

Q. Yes, sir.—A. This record hasn't got anything to do with this. I am merely trying to find out why I was dragged down those steps unconscious, and then put in a mental ward. They didn't even examine me for a mental case. I never had any examination whatsoever.

Q. And they wanted 2 days afterward to take you out?—A. That is right.

Q. And every day afterward they wanted to take you out?—A. That is right.

Q. Well, I don't know how to get that information except going to the record. Now, if you will give me the name of your friends I will talk to them.—A. I gave you the name of the OD.

Q. What is the name of the OD?—A. That told me about the case afterward?

Q. Is he a doctor?—A. That is right. Dr. Meyst.

Q. Is he still in the hospital?—A. Yes, sir.

Q. Can we get him over here to testify now?

Major FROEMMING. Well, it is almost 5:30, he is off duty at 4:30. I would suggest that this gentleman permit us to quote from the records. They are merely facts that we will relate here.

Mr. MULLEN. That is a matter that you have got to determine if you want to let them open them. It is just solely in your hands. I can't tell you, I don't know what is in them. I don't know what is good or bad.

The WITNESS. I am not ashamed of my record. I haven't got anything that I am ashamed of.

By Congressman DOMENGEAUX:

Q. I think your attitude has been very good. I think you are trying to be fair. You want an explanation that there may be an explanation to it.—A. I tell you as far as I am concerned I am not ashamed of my record.

Q. I don't see why you should be.—A. If it is fair and square but I don't know what they put in that record.

Q. Well, I—A. Personally I know that I haven't done anything that I am ashamed of.

Q. The testimony in your case that is reflective against the Administration is that you were dragged down these stairs in this unconscious condition?—A. Yes, sir.

Q. Thrown into an automobile?—A. That is right.

Q. And put into the mental ward?—A. That is right.

Q. I think you should let the records come into the record to clarify it, if you want to.—A. Okay, I will let them come in.

Congressman DOMENGEAUX. Show that the witness gave official permission to the doctors to discuss and to read from his official records of the hospital.

Major FROEMMING. I would like permission to bring his case up to the point where he was taken to the hospital.

Mr. MULLEN. No; he did ask for that.

Major FROEMMING. That is definitely a part of it.

Mr. MULLEN. He didn't grant you permission to do that. Commencing at the stairs where this thing happened, what took place when you picked him up, the medical report. He didn't ask anything else. Pick it up at the stairs or pick it up where he took the tablets, pick it up from there and then limit yourself solely to the medical phase; that is the only thing he gave permission for. After all, he doesn't know anything about what you put in there.—A. That's what I said, I don't know; as far as my record is concerned, I am not ashamed of it, if it is on the square.

Mr. MULLEN. We are willing to believe that a medical man wouldn't put false statements in there, not that other men would understand.

Congressman DOMENGEAUX. Well, I don't believe that there is any foundation, or suspicion, or implication, that any of these records are not correct to the best of their ability. It would be a terrible condemnation on the officials of this Government who are left with the duty of making up these records that would fabricate them. I just can't believe that those things are done. I think, however, that if you want the explanation why you were put into the mental ward, there may be an explanation for it. I mean, starting from the time that he took sick.

Mr. MULLEN. Well, that is the part I mean, from the point where he took the medicine, or the pills, whatever it is, and the medical men no doubt took a hold of them, as he said, himself. Then what their report is, what he wants read in here to explain to him what happened there.

Congressman DOMENGEAUX. Suppose, I don't know, the records have never been discussed, but suppose there were indications prior to that which would justify a diagnosis of a temporary psychosis, you can see that.

Mr. MULLEN. No question about that but—

Congressman DOMENGEAUX. And the record is what is going to disclose it.

Mr. MULLEN. That is true.

Congressman DOMENGEAUX. I mean, suppose—

Mr. MULLEN. I just want this witness, now, to understand that if he gives the general permission he can't complain later. I also want him to know that inasmuch as he has no control over the records and has not seen them; if he admit them, he is in a very poor position to deny them later.

Congressman DOMENGEAUX. Well, he is not admitting anything, he is merely asking what the record discloses. You are not admitting anything about the record?—A. No.

Q. Whether they are correct or false?—A. But here the records haven't got anything to do with how they handled me not knowing what was wrong, my condition.

Q. It may disclose it, I don't know. I don't know of any other way to find it.—A. You will never find anything in the record why they drug me down those steps. That's what I am trying to get at.

Q. Well, it may explain how you were taken there.—A. I am telling you how they took me there. I know how they took me there.

Q. It may have happened, I don't know.—A. It may have happened? I know it happened. I have proof to that effect.

Mr. MULLEN. Well, here is the way I look at that. Perhaps it would be better if they showed you the records in private. Perhaps that would satisfy, get the information.

Congressman DOMENGEAUX. Well, Mr. Mullen, this is a public hearing.

Mr. MULLEN. I understand that thoroughly.

Congressman DOMENGEAUX. These gentlemen are making charges. The newspapers and the press are here. There may be a proper explanation, but he's made the charges. I will say, as a member of this committee, and we have authority to see these records, I will ask that



an explanation of this man's complaints, if the record so discloses, be given to the committee. You may proceed, Mr. Froemming.

Major FROEMMING. Mr. Joseph Brune is a civilian hospital attendant. He has been in our employ since July 3, 1942.

Congressman DOMENGEAUX. You mean he was?

Major FROEMMING. He was in our employ since—from July 3, 1942, to July 3, 1945, when he resigned, giving his reason as being dissatisfied. During the last few months this attendant has been under the influence of liquor. He's become undependable, and although the subject has been discussed with him on several occasions—

The WITNESS. That isn't a medical.

Major FROEMMING. Once in the office of the clinical director. He has made numerous promises to mend his ways but he has failed to do so. He is quartered in Company 11, which is a company used for domiciliary members but not occupied for that purpose at this time; but by our civilian employees who preferred to use those quarters rather than move on the outside. A report came to the guardhouse that this man was in bed with a strong odor of liquor on his breath, and the guards went to the building, satisfied themselves that the man had been drinking heavily, and two men proceeding to escort him from his bed to the outside of the company where we had an automobile, in which he was conveyed to the guardhouse. Upon arriving at the guardhouse it is the custom at our facility to call a physician immediately, who examines the man, determines whether he is drunk or sober, and also determines whether he can be safely kept in the guardhouse, because basically all our men are disabled. In this case we were dealing with a civilian, but, nevertheless, the usual procedure was carried out. Now, from here on we will turn it over to Colonel Bresnahan, because it is a medical record.

(Witness excused.)

Lt. Col. JOHN BRESNAHAN resumed the stand, was examined, and testified further, as follows:

Reexamination by Congressman DOMENGEAUX:

A. Joseph Brune was admitted June 20, 1945, under the present cause of illness. The veteran admits drinking June 16, 1945 to June 18, 1945; on the afternoon of the latter date took some luminal tablets. [Reading:]

I don't remember what happened until I came to in the hospital.

He was examined by the doctor in charge of the ward 26 and a diagnosis of psychosis; intoxication, alcohol; and drugs, barbiturates. He was given an examination by two of the doctors on those wards 26 and 27. Dr. Liberman, the chief of the neuropsychiatric service, and Dr. Berger, physician in the neuropsychiatric service, under the date of June 26, 1945. They state [reading]:

This patient was admitted as an emergency from the attendants' quarters June 20, 1945. He was seen by the sick-call physician—

that's the O. D.—

shortly before his admission and he reported the odor of alcohol on his breath and that he could not be aroused. He was seen at 5:30 p. m., on that day by the undersigned and at which time he was comatose and did not respond to any external stimulus. His color was pink. Eyes closed. Pupils dilated. Right pupil was regular, left somewhat oval. Both reacted to light. The cornea reflex

was present. The upper deep reflexes were present. The lower were reduced, the right more than the left. The left cremasteric active. Right reduced. Abdominals were not obtained.

Q. Why was he put in the mental ward?—A. Because he was psychotic.

Q. A psychotic?—A. Yes, sir.

Q. What does that mean, generally?—A. That means that he was under the influence of alcohol and drugs, and didn't know what he'd do when he came out of them. The discharge summary reads:

The veteran was transferred to the hospital from a domiciliary on June 20, 1945; at the time of admission he was comatose and his bladder was greatly distended. He was catheterized and 1,500 cubic centimeters of urine was obtained and subsequent examinations revealed an alcoholic content of 0.24 percent.

Q. Actual chemical tests were made?—A. Yes, sir. [Reading:]

He responded to treatment and on the morning of June 21, 1945, he was awake but complained of headache and weakness. He admitted drinking and taking 4 luminal tablets prior to his admission. At the present time he has entirely recovered from his intoxication and may be discharged as having obtained maximum benefit from hospitalization.

That is signed by Drs. Liberman and Rhea and Dr. Berger. That is the sum and substance of it.

Congressman DOMENGEAUX. Thank you, Doctor.

(Witness excused.)

JOSEPH BRUNE resumed the stand, was examined, and testified further as follows:

Examination (continued) by Congressman DOMENGEAUX:

Q. Do you have any comments on that, sir?—A. Congressman, I can't believe, if I had been drinking previous, which I admit I had a few beers, but from Monday until Wednesday, do you believe that you could smell alcohol on a man's breath?

Q. Well, you are trying to make me an expert on alcohol.—A. The OD told me, himself, that he did not smell any actually on my breath and that he didn't know what to do. None of them, he says, none of us knew what to do because we didn't know your condition, what you had taken.

Q. Well, I think—A. He said, "I admit that I didn't smell any alcohol on your breath."

Q. I think your condition, from the clinical records and from what you say, was certainly one of sleeping tablets or luminal or whatever it is.—A. That's right. I admitted that afterward. I couldn't tell them while I was unconscious.

Q. It looks that way; but still I don't know what I would have done if I had been a doctor. I mean if you had to be given medical attention.—A. But do you think—

Q. And admitted to save your life.—A. Do you think that was right after the OD found my condition the way it was why they should of dragged me down the stairs? They have got ambulances, they know I am an ex-serviceman; why drag me down the steps and handle me the way they did and bring me to 26?

Q. I think it would have been much better if they had gotten a stretcher and gotten an ambulance, and I think that would have been better; but in the operation of a hospital of that kind, from observation, that's one of those few cases that come up. I don't think that

is the practice. I think that they could have probably gotten a stretcher, particularly when you were in that unconscious condition and——A. Well, you know what it stated there, how long it took me to come to.

Q. But these guards at the time, it was possibly a bad judgment on their part in just grabbing you up and just bringing you there. I can't condemn the whole hospital for that one instance. And the fact that they wanted to take you out of this mental hospital just as soon as you recovered indicates that as soon as your psychosis and condition had improved every day they wanted to take you out and you would not go.—A. If I had been under the influence of liquor the way he states, I probably would have caused some trouble, which I have seen many cases under alcohol do. I have seen plenty of them.

Q. But, you see, how are they to know, and you were unconscious, and you couldn't say what had happened to you; and there was some evidence of you having been drinking. Was it not logical to believe that your condition was possibly the result of alcoholism?—A. No, sir; not in this condition. Alcohol doesn't leave a fellow in that condition.

Q. I have seen them pretty stiff at times.—A. Yes, you can arouse them. You can get some reactions from them. I have never seen one yet——

Q. Well, the worse that this is, is this is a case of bad judgment, that is the worse.—A. And the O. D., himself, told me that he could not smell any alcohol on my breath and I doubt very much if anyone did under those circumstances; from Monday till Wednesday I don't see how they could. I don't believe that alcohol stays on a man's breath that long. All right, here is some more stuff here. While a patient in 26 I had the opportunity to see a lot of things there. They had a couple of patients, one by the name of Herbert Darsch, D-a-r-s-c-h; he was brought in this mental ward as a patient while I was a patient there. This man was in a sort of a trance. I mean it was a mental condition all right; but he wasn't a real bad patient, that is, to handle. You know, he never harmed us. One Sunday—did that fall on Sunday that week—his son, who is an officer in the Army at the present time, his daughter, and his wife came there to visit him, and with his mental condition he was unable to recognize them. This man would stroll up and down the hall, and in a large room that they have there for these patients, would just walk all day back and forth, back and forth, just in a trance.

Q. I have seen that type.—A. And he refused food. They would force down liquids in him, force down the medicine. But in this man's condition an attendant working on that ward at that time took advantage, different opportunities that he had, and would handle him pretty rough.

Q. What is the name of that attendant?—A. Frank Francis. He is here.

Q. In what way would he handle him roughly?—A. Well, in one instance this man would stroll down the hall, he'd look out that little place, peephole there in the door, and then he would stroll back and then he would stroll down there harmlessly, he wasn't harming anyone. "Come on, get out of here," and he'd grab hold of him by the arms and he would drag him down there. Then when he had bath day under this mental condition he didn't know how to take his clothes



off or put them on. Because I was sitting right out in the room and watching the whole show while he was giving this man the bath.

Q. This same attendant, Francis?—A. That is right. This man was sitting down there trying to take his pajamas off. He would tell him to take his pajamas off. He would just sit down there, no move in him, and he got mad and he pulled them off. Then the same way after he got his bath.

Q. You mean he would take them off of him?—A. He finally pulled them off of him. He must have been in there at least 45 minutes. Then after the bath that was the same occurrence.

Q. Put back on the clothes?—A. He didn't want to put them on, this man didn't know what he was doing.

Q. Well, he actually had to handle him bodily and physically to take off his clothes and put them on, did he not? How else could he have done it?—A. Who do you mean, the attendant?

Q. The attendant.—A. He was trying to make the patient take them off himself.

Q. To bathe him?—A. That is right.

Q. And then, afterwards, he would do the same thing to try to make him put the clothes back on?—A. That is right.

Q. Now, there, let me get this. They have got to give these people who can't take care of themselves—A. Why treat them so rough though?

Q. Baths.—A. This man—

Q. How did he treat him rough? I mean in what way? What did he do to him?—A. Well, he was pulling him down the hall, yanking him down the hall.

Q. To take a bath?—A. That is right; no, not to take a bath. Whenever he would go down the hall, it is funny, all the rest of the attendants on that ward there was never any trouble, and when this man is on the ward there is a commotion up there from morning till night. He is not a man for a mental ward. He has those patients, those patients are in a nervous condition, to start out with, and to have anyone holler and yanking at you all day long for 8 hours.

Q. Well, how did he, in what manner did he treat him roughly except that which was essential?—A. Essential?

Q. No; but I mean certainly you treat a man rough when you take his clothes off; I mean you have got to use some bodily effort, some physical effort to take a man's clothes off when he doesn't want to take them off?—A. I have handled patients that are unconscious, I never handled them rough, bed patients. There is a way of taking clothes off without yanking them and pulling and jerking on them. I know from experience, I have handled plenty of them that's been conscious. Now, there is another patient by the name of Jack Eckel, E-c-k-e-l, and he is a mental case, naturally. This fellow has sulky spells, and at times, you know, he is not a real bad patient.

Q. Yes.—A. But I noticed there certain days that he would have these sulking spells and didn't want to cooperate with anyone, you know. Well, the rest of the patients would humor him along to get him to sit down, he would be all right. This Francis would get so mad and grab hold of him, slam him down in the chair. This man must be pretty close to 80 years old, and a very small man, built man, small frame. I have seen that with my own eyes while I was up there.

Q. Yes, sir.—A. Another thing I want to bring up about this Darsch case was one evening when he was dragging him down the hall I sent one of the other attendants for a nurse. The nurse came in and I asked her what authority this attendant had in manhandling these patients the way he was doing, especially this type of mental case.

Q. Speaking of Francis again?—A. That is right. And she walked out and I never got any comment from her. Now, I don't know what this nurse's name is but I guess the records would show. She was on at the time, it wasn't the blond supervisor, it was the one under her. That is all I have on that case.

Q. I see. Anything else, sir?—A. Yes.

Q. Do you consider that cruelty when you are speaking of the Darsch case?—A. That is right.

Q. When a man doesn't want to eat and he has got to take his medicine?—A. No, I don't; not that part of it I don't.

Q. Yes, I just didn't want to—A. Because I know this man. He was really, he was in a trance and he didn't know what he was doing. I know that they had to force this medicine into him, that was perfectly right. Now, this attendant that I am referring to here—

Q. Have you difficulties with this man yourself?—A. Who is that?

Q. With Francis?—A. No, sir; no personal feelings there at all, or treatments. This attendant that I am referring to here, I don't know his name; but I guess Miss Metcalfe could furnish you his name. He hurt his back on ward 22 lifting a patient, reported it to the doctor.

Q. Now, are you speaking of things of your own knowledge?—A. He told me this himself, personally. And I can get this patient here to verify these statements.

Q. What is his name? You don't know?—A. Do you know that young fellow's name, Miss Metcalfe, that was working on 22 at the time he hurt his back?

MISS METCALFE. There are so many hurt their backs on that floor.

THE WITNESS. This was a tall, young fellow, while I was in the hospital just recently.

MISS METCALFE. Casseron. I think his name is.

THE WITNESS. Casseron. He went to the OD, told him that he was able to work. He was also told by Miss Petty, "If you can walk, you can work."

By Congressman DOMENGEAUX:

Q. Well, I am leaving this in, but technically that is hearsay evidence you have.—A. Hearsay?

Q. I mean, do you have any personal knowledge?—A. This man, this attendant, I am going to get down to that now. This attendant was sent then on ward 27. That is—

Q. Mental ward?—A. No; it is a ward right next to the mental ward, on the same floor.

MR. VOGTMAN. An open ward.

THE WITNESS. It is an open ward. He was sent to 27 because there isn't hardly any bed patients up there; but they have a lot of seizure cases there. The patient, Bill Weikert, who was the attendant on 27, was then sent to ward 22. I was a patient in 26 eating supper. He rushes in.

MR. MULLEN. When you say "he" you better tell them who you mean by "he."

The WITNESS. This attendant who hurt his back.

By Congressman DOMENGEAUX:

Q. Yes.—A. He rushes in 26. There is a patient on the floor with a seizure in the hall. The attendants couldn't leave 26 at mealtime. They have to be in the dining room, and naturally, they couldn't leave the ward, and in his condition he was unable to lift the patient, so this patient lay on the floor in the hall until he could find help.

Q. You don't know how long that took?—A. I don't know. I would like to get that fellow up here and tell his story. It is an actual fact because the man, the way he told me he has to relieve——

Q. Well, we will get his testimony and get his personal knowledge of those circumstances.—A. Now, this is an attendant, Harry was all I knew him by. Miss Metcalfe could furnish us his name. He works at the Oil Gear Co. I could find him for you. He had a broken jaw. He got hit with a car on the outside. Jaw was not healed and was on a liquid diet.

Q. That is an attendant?—A. That is right. Miss Metcalfe told the doctor is discharge him as she was short of help.

Q. How do you know that? Do you know that of your own knowledge?—A. He told me that himself, personally. This is another man that I would like to get down here.

Q. Give me the names of these people. I don't think it is competent to testify on what someone told you. I want to be fair.—A. I know this case myself.

Q. You have personal knowledge?—A. I know this case. I have seen the man and I know his jaw wasn't healed when he went back to work.

Q. How do you know what Miss Metcalfe——A. He told me, that is the reason he got discharged.

Q. Well, the proper evidence is for him to come up and testify.—A. Well, I will bring on another case.

Mr. MULLEN. Probably he would like the man's name that you just referred to, with the broken jaw.

Congressman DOMENGEAUX. That is Harry who? How are we going to identify him?

The WITNESS. He worked on 8 or 9. I never knew his last name. He is a young fellow.

Mr. MULLEN. Give us the man's name.

Miss METCALFE. I think I know the man's name that he is referring to, but I would have to look up the man's name—is it Mueller?

Mr. MULLEN. Maybe we can get that later?

Miss METCALFE. Harry Mueller?

The WITNESS. Yes, that is it, Mueller. The doctor said he was——

Mr. MULLEN. Wait a minute, just tell—I mean those things you know.

The WITNESS. Oh, I see.

Mr. MULLEN. They are going to call these men if you know their names.

The WITNESS. Caspari, sugar diabetic case, was operated on——

Mr. MULLEN. Give him the correct name. Do you know the spelling of it?

The WITNESS. Caspari.

Major FROEMMING. Lawrence Caspari, C-a-s-p-a-r-i.



By Congressman DOMENGEAUX:

Q. Each one of these men are going to be individually contacted, and I will get their story.—A. That is right.

Q. Any other names, sir?—A. Oh, yes. I have something here about No. 2 annex. I think there was a statement made by Mr. Froemming that he would give a nickel for every cockroach that you found in the hospital. I worked on 24 and 25. In the morning—that is early morning—about 5 o'clock or 6, we were getting patients up, found cockroaches in bed with patients, and that is every morning occurrence.

Q. What ward is that in?—A. 24 and 25. Twenty-four is the colored ward. There was two patients that I got up every morning. One of them had sideboards on. He was sort of paralyzed on one side, and every morning I would find cockroaches in that fellow's bed.

Q. Do you know whether an effort was being made to get rid of them?—A. I do not know. I worked up there, as I was on relief at that time, and I worked up there for a week and during that whole week there wasn't a morning that I didn't find cockroaches in that bed.

Q. Just in that particular bed?—A. No, in other beds. Now, the sleepers, these patients—

Q. Well, now, are you on duty at that time?—A. That is right.

Q. What did you do to try and get rid of these cockroaches? Did you report it?—A. I reported to the nurse that there was cockroaches in there, certainly.

Q. Did you take any—did you do anything to try and prevent it?—

A. What am I going to do to prevent them? I haven't got anything that would prevent them. I have never seen anything in the ward to use to prevent them. And, in the first place, the night men, when you are getting patients up there in the morning you don't have time to take care of cockroaches. You have got plenty of work to do besides taking care of cockroaches. Sleepers in ward 23, that is the nursery. They have 12 beds in there. These 12 patients are practically helpless. There was 2 patients in particular in this room that they keep muslin over their heads to keep the roaches from crawling in the mouths. These sleepers, their mouths are open practically all the time.

Q. Parkinsonia cases?—A. That is right.

Q. Well, then, the best precaution, I mean they were doing something to prevent those cockroaches at that?—A. They were on that particular point; these 2 particular patients—

Q. That is an old building, isn't it? How old is that building?

Major FROEMMING. It is a very modern building. It is about 12 years old, and we have very little difficulty with the vermin in a building of that kind, of an's or anything that might get into a building because of its modern construction. I would like to—when this gentleman gets through—have Miss Metcalfe discuss the general conditions in the ward as to roaches in that building.

Congressman DOMENGEAUX. Yes.

The WITNESS. I guess that is all I have.

(Witness excused.)

Congressman DOMENGEAUX. Would you like to explain the vermin condition on that ward?

Miss METCALFE. In every hospital, in every public building, I think, you have some trouble with roaches, but we work just as hard as we can to keep them out of all of our hospital buildings. I have been

criticized for cleaning too much, but we clean in order to keep those conditions down.

Congressman DOMENGEAUX. What steps do you take to prevent them?

Miss METCALFE. We have sodium chloride that we use and then we also have a sprayer. Our head attendants spray—I think Lane is on afternoons; now, they spray twice a week, isn't that right?

Mr. JOHN S. LANE. That is right.

Miss METCALFE. In Annex 2, in all the wards, that mosquito netting that we use is not used to keep cockroaches out, it is used to keep flies, which do get in, off of their faces, because these men are not able to lift their hands and yet they are conscious, and it would be an awful thing to have a fly crawling around on their faces, and that is what we use that for.

Congressman DOMENGEAUX. To keep flies off?

Miss METCALFE. Yes.

Congressman DOMENGEAUX. On which occasion they come into these places.

Major FROEMMING. Mr. Domengeaux, Mr. Francis, one of our attendants, is here. Would it meet with your approval to have him testify in his own defense?

Congressman DOMENGEAUX. Yes.

Mr. Francis. You take the stand, sir.

FRANK A. FRANCIS, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. You heard the testimony of this gentleman that just preceded you?—A. Yes, sir.

Q. You know the patient, Darsch?—A. Darsch, D-a-r-s-c-h, is the name, Herbert.

Q. It is charged that you have used unnecessary physical restraint, efforts on this poor individual?—A. Well, I retract that is not true. Now, this party Darsch, who is now in Downey, was a very badly disturbed patient. I had orders to keep the man out of the hallway. Now, he had a tendency to stay up at the door just as he said; but he wanted to get out. He couldn't understand why he was there, and the man would not move. You couldn't make him, particularly, understand at times: at times he did, at times he didn't. And I assisted him down the hall. He, naturally, would hold back, but I took him back to the riot room where he could be watched and under observation. There is nobody out in the hall to watch those men. If a nurse opens the door a man can go out. He is not responsible. I didn't use any undue force. It was not necessary to take him down there.

Q. He would fight back when you were trying to take him?—A. He would resist. He didn't fight with his hands, no, sir; but he would, you know what I mean, he would pull away from you and he wouldn't walk, and he wouldn't move, and at times you couldn't make him understand that he was supposed to come back; other times he would follow me around, right at my back.

Q. What about the instances when you took—it is necessary to bathe these people, isn't it?—A. Absolutely, and I was trying to help the man, more than anything else. I was trying to impress him with the

idea that he should take off his linen, and so forth, and when I had to take it off for the bath he resisted, that is, you know what I mean. He didn't want them off. He didn't care about going in the bathtub. But as far as being irritable or anything of that nature, I don't think that my record has ever showed it. I have been up there for a period of 6 years and I have never been under any particular investigation before, as my record will show.

Q. Were there any charges ever made against this gentleman?

Major FROEMMING. Not to my knowledge.

Congressman DOMENGEAUX. Any complaints ever urged against him that has ever been called to your attention?

Major FROEMMING. Never brought to my attention. He is one of our old trusted employees. We are very proud to have him there on duty in that ward.

By Congressman DOMENGEAUX:

Q. Were you an attendant in a hospital before coming over here 6 years ago? You have only been an attendant for 6 years?—A. I have been an attendant there since May 6, 1938.

Q. And prior to that what did you do?—A. Prior to that I was with the du Pont Co.

Q. Now, what about this Jack Eckel? Do you remember that case? The old blind man?—A. Yes. Now, I tell you Mr. Eckel is a man that we have had in there between 2 and 3 years. He is a man of, he is an elderly fellow but is hard as nails, and he has never been able to orient himself in that ward, and once in a while, as Mr. Brune says, he gets rambunctious and he travels around. We have other patients there in room that are not so good, either, such as McMulkey.

When this occasion happened this party, Jack, had gone in there and Mike was on the tear. I thought he was coming right out of bed; every time Jack gets near his bed he just goes into fits. Well, this fellow Jack—I went in and tried to get him out. No, he wasn't coming out. He wasn't going to do this or do that or the other thing, and he walks around, he is liable to stumble and hurt himself; if he falls he is liable to break a hip and I did, I took him under the arms and assisted him out, and sat him down in the chair. Now, it might have seemed unduly hard, but still I didn't hurt the old gent.

Q. And if you hadn't done that he would have gotten into a fight with this other fellow?—A. That is right. Now this little old fellow, it took four of us to give him a bath under the doctor's direction, and the doctor was there at the time. We wouldn't even give him a bath without the doctor's orders. Every time you want to give him a bath he objects, and you have to handle him in that way. That is all you can do and then he will get up again and he heads somewhere else. He is blind, he goes here and he stumbles over there; it is a matter of the welfare of the patients. There has got to be order up there and, you know what I mean, but we never, I have never used any severe method in handling these patients but what I have had to do.

Q. Have you every known any—I wouldn't expect you to answer it because I presume the ethics of your profession wouldn't allow it—I don't believe attendants squeal on each other, and I am sure that there have been instances in these hospitals throughout the



country where attendants became impatient, have lost their temper, I am sure that you have attendants up there of different temperaments, and different disposition?—A. Yes.

Q. Have you ever known any attendants up there, since you have been at Wood, to be unduly harsh and unkind and cruel to these patients that the circumstances didn't justify?—A. Well, not on my particular shift; no, sir. Not that I saw with my own eyes. There was one occasion, a case came up that I heard about, but I didn't see it.

Q. What would happen to an attendant if he was unkind to a mental patient and brutalized him, and that could be established and proven?—A. In our particular institution up there he would be dealt with and he would be dealt with fairly.

Q. And if it could be proven, would he be dismissed?—A. Absolutely; yes, sir.

Q. Do they show—do the authorities in any way condone cruelty of any kind?—A. Absolutely not; not any cruelty whatsoever. Of course, there is such a thing as self-preservation in the case of a man in dementia furor where we have to use extreme means; but we never mutilate, we never use any extreme methods; we never have, up there.

Q. And if an attendant used extreme methods without justification of the circumstances he would be dismissed from the institution?—A. Absolutely.

Q. He is not given a second chance?—A. Not to my knowledge; at least, that has always been my understanding.

Q. Well, I think the attendants in this country and of mental hospitals have done and are doing a good job.—A. Well, I am glad to hear that.

Q. And I believe that there have been instances where men have lost their temper and have been unkind and, possibly, cruel to patients, but that, in my opinion, is the very rare case, very rare case. I heard of no such instances at Wood, and it is a very hard, difficult job to be an attendant in a mental ward.—A. I appreciate that.

Q. You have some of those poor unfortunates who will occasionally spit on you, won't they?—A. Oh, yes. I have tobacco juice in my face; yes, sir. We have had one patient up there that we used to call—what was it—he was an ex-woodsman, tougher than nails, and he would come right up and spit tobacco juice in your face time after time, and ask for a fight.

Q. Yes; he wanted to fight.—A. Oh, sure.

Q. I think that is all, sir. Do you want to ask any questions on that? That is more or less different from your story?

(No answer from Mr. Brune.)

Q. It is a matter of judgment to determine whether the extent of the force used—that is the question.

MR. BRUNE. Well, I tell you the other attendants never have any trouble up there with those patients. That is what I am referring to.

THE WITNESS. Well, I wouldn't particularly say that.

MR. BRUNE. And I think that he has too much of a temper for that ward.

CONGRESSMAN DOMENGEAUX. I see. Thank you, sir.

MR. BRUNE. What my experience has been.

CONGRESSMAN DOMENGEAUX. I see. That is all, thank you.

The WITNESS. That is all. Thank you.

(Witness excused.)

Mr. MULLEN. We have one more girl—that should't take long.

Congressman DOMENGEAUX. All right. Did you want to make any comments about any of this?

Major FROEMMING. No. I have none to make.

Congressman DOMENGEAUX. What are the regulations of the Veterans' Administration relative to the disciplinary actions taken against an attendant who may unwarrantedly brutalize or use cruelty against patients?

Major FROEMMING. Well, our attendants are United States civil-service employees, and when conditions—or if conditions of brutality should be brought to our attention, we would prefer charges against them. They would immediately be taken off of the service and, perhaps, assigned to other services. If the charges were severe enough, we would suspend them until they had an opportunity to answer the charge and it had been submitted to Washington for final disposition.

Congressman DOMENGEAUX. But actually, as a matter of fact—and I think something should be done in that direction; don't misunderstand me; I don't believe that you have any condonance of brutality; I don't think it takes place except in very rare cases—but actually it could go on and among these poor unfortunate people who cannot talk, and if they do you can't put any credence to what they say, and I am sure the attendants stick by each other; how are you going to stop those things when they do occur? I know the Veterans' Administration has had to send in in some hospitals—

Major FROEMMING. All marks or bruises—

Congressman DOMENGEAUX. They have had to send in under-cover people—

Major FROEMMING. All marks or bruises or fractures that are sustained by patients are immediately investigated and, of course, that generally develops the fact whether or not there is a possibility that he could have been injured due to rough handling. The patients, of course, cause considerable damage to themselves due to their own condition.

Congressman DOMENGEAUX. Yes. But actually it would be most difficult, and you would have to have practically an outright case where a competent eyewitness would be there to testify because the poor unfortunate insane is not in a position to testify.

Major FROEMMING. Our mental service at Woods is very small and it is ably supervised.

Congressman DOMENGEAUX. I am speaking of the general policy. Isn't that more or less—it is a very difficult thing to get to the facts of what has actually occurred in a mental ward because of the complexity of the situation and the incompetency of the witness?

Major FROEMMING. I presume it would be.

Congressman DOMENGEAUX. Yes, I think so.

LILLIAN STELTER, appearing as a witness herein, was examined and testified as follows:

Examination by Congressman DOMENGEAUX:

Q. What is your name, please?—A. Mrs. Lillian Stelter, S-t-e-l-t-e-r.

Q. Now, Mrs. Stelter, we are happy to have whatever you have got to say, but I am going to ask you to restrict it to facts of your own knowledge, things that you have seen yourself, things that you know—A. Well, I have always wondered why my husband was always passed up in a raise after he worked there for 3 years.

Q. Well, Madam, that is an administrative matter and it is not the function of this committee—A. And why other employees that came there after him that was given a raise?

Q. Well, that is an administrative matter, and I can't go into that as to why one employee got a raise and one didn't get a raise. I mean it is not the function of this committee to determine that.—A. Then you aren't interested in the condition at the hospital?

Q. Well, I am interested. Do you want to explain why he didn't get a raise?

Major FROEMMING. Well, I would say that this lady, her husband has never come to my office to my knowledge and discussed their problem with me.

The WITNESS. He didn't work under you.

Major FROEMMING. I would be very happy to discuss it with you and I am sure that we would make the proper adjustment.

By Congressman DOMENGEAUX:

Q. He is not living now, is he?—A. No; he isn't.

Q. How long has he been dead?—A. 4 years. And why did you send me so many letters when I took my furlough last summer under the doctor's orders? Miss Metcalfe told me that I was to have the furlough and you said you were taking steps to dismiss me.

Q. Well, Madam, testify to what you know and don't ask questions. This is a personal matter and I want to give you every opportunity, but that is an administrative proposition. Can you explain that, Major?

Major FROEMMING. I would rather have the record. I have it here some place, I believe.

By Congressman DOMENGEAUX:

Q. What is the complaint? Because he wrote you so many letters?—A. Yes.

Major FROEMMING. This lady occupied one of the positions that is authorized on our organization chart and she has had long periods of leave. She has exhausted her annual leave, all accumulative sick leave, and we have had her on leave without pay. Now, we cannot fill that position as long as it is assigned to her, even while she is on leave without pay, and it is our policy, when employees have long periods of leave, to investigate to see the cause. If it is due to a physical condition we have them examined by a board of three physicians in order to determine whether or not they are entitled to consideration under the retirement act under which, after 5 years of service, they can be retired for physical disability. Naturally, in our personnel department we have over 1,500 employees; we have a system by which we follow up these cases of long leaves where the position is on our organization chart but the employee is not on duty, and we are not authorized to hire someone else while that position is being reserved for that particular employee. I think it is only ordinary business procedure to determine the facts in the case.



The WITNESS. Miss Metcalfe assured me that I could have the 3 months' furlough.

Congressman DOMENGEAUX. Do you know anything about that, Miss Metcalfe?

Miss METCALFE. Yes; I do know Lillian has been sick a lot. She is a very good attendant, and I felt that we would do anything we could to help her through. She needs to hold the position. So I did talk to the Personnel and ask them how much time we could give her and they said we can give her all her sick leave and 30 days' leave without pay, and then we will have to write in to Washington to get more time. And that was the purpose of the inquiry, I believe, to know how much more time she needed so we could get permission from central office. And I believe you were given every bit of time that you wanted, weren't you, Lillian?

The WITNESS. Well, yes; but I was receiving letters all the time, threatened with a dismissal.

Major FROEMMING. We don't threaten anyone. We merely state the steps we are compelled to take under the regulations. This employee has had more leave without pay than any other employee that we have ever had on our pay roll.

By Congressman DOMENGEAUX:

Q. You are not able to come back to work?—A. Yes; I am able. I didn't ask my doctor for any information. He recommended, when I took my daughter to him, that I take a furlough.

Q. Yes, Ma'am.

Major FROEMMING. Miss Metcalfe states that this employee has an efficiency rating of excellent.

Congressman DOMENGEAUX. Yes; very good, I understand.

Major FROEMMING. But I have never met the lady before, face to face. She has never come in to see me, but I do remember the correspondence in the case because it was so outstanding.

Congressman DOMENGEAUX. Well, I suggest, then, that you all come to some understanding and have a meeting of the minds, if you are satisfied to go back to work and able to go back to work.

Miss METCALFE. Congressman, she is back on duty. She has been back.

By Congressman DOMENGEAUX:

Q. Oh, she is back? Then what is the trouble?—A. Then why was that attitude taken toward me?

Q. Oh, well, because of writing these letters and——A. And why did Miss Metcalfe take me in her office and ask me to explain why I was a friend of John May's?

Q. I don't know. Why did you do that, Miss Metcalfe?

Miss METCALFE. I didn't. Someone came and told me that Lillian was circulating a petition, some of the attendants.

The WITNESS. That was not true.

Miss METCALFE. I called Lillian and asked her what her complaints were, complaints about the hospital. Not because of anything except I wanted to know, and she said, "I have no complaints. I have had the very fairest treatment." But she brought up this about her husband at the time and then Lillian made a lot of remarks, in the

course of the conversation, that I don't believe I would like to tell you; and I don't believe she would want me to tell you.

The WITNESS. No.

By Congressman DOMENGEAUX:

Q. Well, we will forget what was said. What else, Ma'am?—A. And then when I had worked at the hospital 4 days I was walking and talking to Mr. May in the hall relative to some affairs of my family. And Miss Petty asked me to come back to her, she met us in the hall, after he left me.

Q. Was it interfering with the work?—A. I was on my lunch hour.

Q. On your lunch hour?—A. And she said, "Mrs. Stelter," she said, "I have seen you walking and talking to Mr. May." And I asked Miss Petty what her objection were to that and she said that he had made them a lot of trouble; but she said, "I do know of some good things that he has done." I said, "I have never had any fault with Mr. May."

Q. Well, what is wrong with that? The observation?—A. But why should I—I was never asked why I was walking and talking with any other attendant?

Mr. MULLEN. This was all after your husband died?

The WITNESS. Yes.

By Congressman DOMENGEAUX:

Q. And she didn't tell you not to talk with Mr. May?—A. She told me, she didn't tell me not to; no. She said that he had made them a lot of trouble.

Q. And had also done some good things?—A. Yes; she did say he had done some good things that they knew about.

Q. Anything else?—A. Not right now.

Q. All right. Thank you, Ma'am.

(Witness excused.)

Congressman DOMENGEAUX. I don't think there is any necessity of going on.

Major FROEMMING. I would be glad to have Mrs. Stelter come in and discuss her problem with me. I would be glad to adjust——

Mr. MULLEN. Did you hear what the major said?

Mrs. STELTER. How?

Mr. MULLEN. He would be very glad to have you come into his office and discuss your particular problem with you at any time.

Mrs. STELTER. Thank you; I will do that.

Congressman DOMENGEAUX. Anybody else?

Mr. MULLEN. Anything else, May?

Mr. MAY. No; not that I know of.

Congressman DOMENGEAUX. Anything else?

Mr. MAY. They talked about coming, but I don't know where they are at.

Congressman DOMENGEAUX. Do you have any statements that any of you gentlemen care to make?

Major FROEMMING. Any statements you want to make?

Lt. Col. JOHN BRESNAHAN. No.

Major FROEMMING. We haven't anything further. We are meeting again tomorrow, are we?

Congressman DOMENGEAUX. No; I don't see any further reason to.

I can't hold these things open indefinitely. I have got to bring them to a head.

Miss METCALFE, you have been with the hospital over here how long, Ma'am?

Miss METCALFE. Since 1932.

Congressman DOMENGEAUX. Anybody else care to say anything? Does that end the testimony?

Major FROEMMING. Mr. Domengeaux, this morning we had the case of Archie Pearson, and it seems that Mr. Pearson was not here because he could not be contacted. We were charged with negligence in this case in not hospitalizing this man for pneumonia which he developed after he left our service. I would like to have someone here, that knows about that case, clarify that for the record.

Congressman DOMENGEAUX. I want that information.

Major FROEMMING. He was employed in Miss Metcalfe's department.

Congressman DOMENGEAUX. What are the facts of the case? That is who?

Major FROEMMING. Archie Pearson.

Congressman DOMENGEAUX. Identified as what in this? Attendant C.?

Will you, please?

Miss METCALFE. He came down to my office and said he was ill. I sent him to the personnel doctor, which is the practice of our office if anyone complains of being ill. The personnel doctor said that he was ill and should be hospitalized.

Congressman DOMENGEAUX. What was he suffering from?

Miss METCALFE. Well, he didn't diagnose the case. He said just upper respiratory, that's what they usually say. So I took, I told this Archie Pearson to wait while I saw the chief medical officer, who at the time was Dr. Thompson, because, of course, I have no authority to send anyone into the hospital; and I went in and at the time we were taking only emergency cases because the hospital was full. So Dr. Thompson said: "Well, if he is an emergency case, yes, we will take him in." So I went back out and Mr. Pearson said, "I don't want to go in the hospital." He said, "I'd rather go home." So he waited while I told that to Dr. Thompson, and Dr. Thompson said, "Well, let him go home, then," and he did go home; and then he did have pneumonia.

Congressman DOMENGEAUX. How long after he left the hospital?

Miss METCALFE. Well, I don't know. I didn't hear from him for about 2 or 3 days so I don't know; but about a year or 2 years ago this same man came back to the hospital and wanted to be reemployed as a hospital attendant. And I said "Why do you want to come back here to work after the things you have said about your treatment?" And he said, "I never said anything about the treatment." He said, "I never had any complaint about the treatment." Well, I took him in to have him examined and he was examined, and they said he was not able to do arduous duties, so he was not reemployed.

Congressman DOMENGEAUX. That is [reading]:

Attendant C, a world war veteran, reports that he underwent an operation for goiter at Wood. Two weeks later he fell ill. Appealing for treatment at Wood, he was rejected. He drove 15 miles to a private physician who correctly diagnosed his illness as lobar pneumonia.



That is the case?

Major FROEMMING. That is right. Mr. Gibson was asked to be here today. Did you have something for him?

Congressman DOMENGEAUX. Mr. May had asked Mr. Gibson to come.

Mr. MAY. I thought maybe some of these witnesses had something.

Congressman DOMENGEAUX. You asked me to summon him and that is the reason. Do you want to examine Mr. Gibson about anything?

Mr. MAY. Not myself.

Mr. BRUNE. Yes, I do.

Mr. MAY. Not at this time.

Mr. BRUNE. I wanted to know who gave Mr. Gibson, an attendant at Wood Facility, the authority to use the theater for a meeting to get petitions signed in regards to this article, I think it was in the Reader's Scope.

Congressman DOMENGEAUX. Do you want to answer that, Mr. Gibson?

Mr. FLOYD GIBSON. If I get it clearly, he wants to know who gave me the authority to call a meeting of the attendant personnel?

Mr. BRUNE. And get the right to use the theater?

Mr. GIBSON. And the right to use the theater?

Mr. BRUNE. Yes.

Mr. GIBSON. My letter was partly self-explanatory. It was in the letter. I said it was a self-appointed committee. If you want the names it was Mr. Lane, Mr. Myklebust, and myself.

Congressman DOMENGEAUX. Who drew up this resolution?

Mr. GIBSON. No. It was no resolution. They had no part in the wording. That was the committee formed by us. We highly resented Mr. May's article, figuring it was a reflection on the service that we were giving the veterans, and we thought something should be done. And as I get it, Mr. Lane got permission from Colonel Mullins to hold the meeting and get the theater, and at that time, why, Mr. Lane informed me that he was on leave, would I take over as chairman, and I said yes; and it was not a petition, it was my letter and my opinion written in the first person.

Congressman DOMENGEAUX. And concurred in by these——

Mr. GIBSON. And read to the assembly, told that they were not forced, or didn't coerce them in anyway to sign; but if they—and allowed to discuss it—if I made any statements that they did not approve of and if they did, they had the privilege of signing it, as I say, in their own self-defense, and I secured some one-hundred-and-thirty-odd signatures.

Congressman DOMENGEAUX. Is it unusual for employees——

Mr. GIBSON. Employees, only, in the personnel division.

Congressman DOMENGEAUX. To get together on occasions and to——

Major FROEMMING. We permit our employee organizations, the unions, to gather in our auditoriums if they so desire, if it does not interfere with anything pertaining to patients.

Mr. GIBSON. In conjunction—pardon me——

Major FROEMMING. In conjunction with any matters that may have, that they wish to present to us. Upon your arrival and your outlining of a policy that all that wished to express their feelings to

you about this matter, we threw down the bars and told them all they could prepare themselves to appear before you.

Congressman DOMENGEAUX. I see no criticism of that.

Major FROEMMING. We have another attendant here who has been with us many years, a Mr. Lane; I would like to have him appear here.

Mr. GIBSON. I wish to say that personally I did not know the Congressman was coming, even when I wrote the letter.

Mr. JOHN LANE. Mr. Chairman——

Mr. BRUNE. That was presented after he come.

Mr. LANE. After hearing quite a few comments about this magazine and talking with quite a few of the older employees who are all veterans, we came to the conclusion that it was a black eye for us.

Congressman DOMENGEAUX. The point is: Was it true or untrue?

Mr. LANE. That's what we wanted to know. We couldn't see any of it, ourselves. As veterans we are potential patients in that institution, and we saw no reason why we should condone anything or any of those articles that were in the magazine. So the thing for us to do was not to bring the meeting to protect management, or the doctors, or the nurses; it was to protect ourselves because we was implicated in that as much as anybody, being veterans, potential patients. We would be foolish to stand for any abuse of that kind.

Congressman DOMENGEAUX. That is correct.

Mr. LANE. So I took it upon myself to go to the chief medical officer and ask his permission, without any suggestions from the management or anybody, if he thought it would be a good idea to have a meeting of that kind. He told me that that was up to us, that there was no restrictions. So I told him I'd like to go to the recreational director there and see if we could have the theater. He just happened in the office at that time and we asked him, and he said that any day of the last week we could have it. Well, I was on leave and so I went to Mr. Gibson and Mr. Myklebust, and spoke to them about it and asked them if they didn't think it would be a good idea to hold this meeting there. There was nothing compulsory about it. We explained that to them and that if there was anything in this letter that Mr. Gibson had written, if they had any objections to any section of it, why, it would be noted; but I will say that it was unanimous. Everybody he read the letter to, and explained it fully, took unanimous action in signing it without any compulsion on anybody's part; and that's the way we feel about the conditions there.

Congressman DOMENGEAUX. Was it held on the Government's time?

Mr. LANE. That's right.

Congressman DOMENGEAUX. Identify yourself, sir. What is your name?

Mr. LANE. John S. Lane. L-a-n-e.

Major FROEMMING. There is an article, Mr. May's article, there is an item about he identified the case of John F. Mitchell, who was not here today but who, it is claimed, was dumped into a bed in our hospital. Would you like to hear a discussion of the general procedure in handling a patient from a litter to a bed by our chief nurse?

Congressman DOMENGEAUX. Yes.

Miss METCALFE. The attendants do most of the lifting. Of course, we have male attendants and they do most of the lifting. The nurses

very rarely are called upon to handle cases but when they do, of course, there are two or more always to take them off and put them on the stretcher. I have never known of a case of that kind; it's never come to my attention at all.

Mr. BRUNE. Mr. Congressman.

Congressman DOMENGEAUX. Yes, sir?

Mr. BRUNE. I'd like to have that letter read, of Mr. Gibson's.

Congressman DOMENGEAUX. Well, it is already in the record.

Mr. BRUNE. Oh, it is?

Congressman DOMENGEAUX. Yes.

Mr. BRUNE. Do you think that was for the welfare of the employees, or the welfare of the higher-up personnel?

Congressman DOMENGEAUX. If it is a voluntary action I think it is a natural reaction from a group of individuals, if it is voluntary.

Mr. BRUNE. Do you think that the manager would give an employee the right, on Government time, to read a petition, collect a petition, if it wasn't for the benefit of their own behalf?

Congressman DOMENGEAUX. They have. Do you allow it to your unions and your other—

Mr. BRUNE. I have never seen it in the time I worked there.

Major FROEMMING. It is permissible under the regulations.

Congressman DOMENGEAUX. It is permissible under the regulations?

Major FROEMMING. Their grievance committees come to see us during Government time; that's permissible.

Congressman DOMENGEAUX. Did you want to say something?

Mr. GIBSON. In that letter was a clause which stated very clearly that it was not a whitewash for any improvable conditions and before I wrote the letter, or before I read the letter, I explained to the assembly of attendants that the doctors could take care of themselves, the nurses can take care of themselves, we will take care of ourselves. It was made very explicit; there was no whitewash for the higher ups. The whole thing was a reflection on an institution that I am a part of, a shareholder in; I am a taxpayer and every other person is, and it is a reflection that me and my coworkers give, the service to me and my brother veterans.

Congressman DOMENGEAUX. If untrue?

Mr. GIBSON. Yes, sir.

Mrs. STELTER. I think the nurses should be applauded for their services to that institution. I have worked under a great many nurses and I have only been insulted by one, and I think that's a good record, that we are under the jurisdiction of Miss Metcalfe and Miss Petty, and—

Congressman DOMENGEAUX. I said I believe that we should applaud the nurses at Wood.

Congressman DOMENGEAUX. Applaud the nurses at Wood?

Mrs. STELTER. Yes; and give them every credit for their work.

Congressman DOMENGEAUX. Does that include Miss Metcalfe and Miss Petty?

Mrs. STELTER. Under the jurisdiction of them, and I have had only one nurse that has really insulted me.

Congressman DOMENGEAUX. But generally you applaud them?

Mrs. STELTER. Under their jurisdiction—



Major FROEMMING. Mrs. Stelter, you claim that one of our nurses insulted you? I would suggest that we find out the details.

Congressman DOMENGEAUX. Who was that nurse?

Mrs. STELTER. It was Mrs. Teichen.

Congressman DOMENGEAUX. In what way did she insult you?

Mrs. STELTER. I was working from 2:30 to 11 under Miss Schiek and Mrs. Teichen relieved Miss Schiek at 11 o'clock, and Miss Schiek asked me a question as I was preparing to bid her good night, and I stepped into the nurses' office to answer her question out of respect to my nurse; and Mrs. Teichen demanded in very firm tones, "Since when has an attendant been allowed in a nurse's office?"

Congressman DOMENGEAUX. That's a very bad attitude, and I—

Mrs. STELTER. And "I thought attendants' work was honorable."

Congressman DOMENGEAUX. Have you checked that up?

Miss METCALFE. No. I never heard about that before. Did you ever make any report about that, Lillian?

Mrs. STELTER. No; I never did.

Miss METCALFE. Have you ever failed to have a satisfactory adjustment of any grievance that you have brought to my office, Lillian?

Mrs. STELTER. I have never brought any.

Miss METCALFE. Yes; you have brought some grievances.

Major FROEMMING. We will be very glad to have Miss Teichen answer that charge.

Congressman DOMENGEAUX. Well, check up that.

Major FROEMMING. Yes.

Congressman DOMENGEAUX. Anybody else care to testify to anything?

Well, we will bring this to a close.

(Which were all the proceedings had and testimony taken in the above-entitled matter.)

(The following was submitted for the record:)

STATEMENTS OF ARDEN E. FENSEL, MILWAUKEE, WIS.

On January 28, 1939, I was struck by an automobile and taken to the Milwaukee County Emergency Hospital. Here the injuries were diagnosed as a simple fracture of the left leg between the knee and ankle. Upon their finding out that I was a veteran, the leg was placed in a wire basket and I was taken directly to the veterans' hospital at Wood, Wis. Nothing was done to my leg from 8 p. m., January 28, till 1 p. m., January 30, when I was taken to the X-ray room and X-rayed. This X-ray could have been taken at my bed with the portable outfit. After coming back the leg pained me more and felt as though it was jammed too close to the end of the wire basket. When my wife came out during visiting hours I complained to her. She found that the foot had turned black and called the charge nurse, who called the doctor, who, in turn, called four other doctors to decide whether they should amputate. The leg had swelled so that the flesh squeezed through the openings in the wire mesh. Dr. Newman took the leg out of the basket, gave it a jerk by the heel, and laid it upon the bed. The black began leaving then, and it looked like gray, angry clouds boiling in the toes. Had a doctor supervised placing the leg back in the basket this would not have happened. Nothing more was done till 10 a. m., January 31. Then I was taken to the operating room, where a pin was drilled through my heel. I was taken into the cast room and put in a traction bed. The leg was placed upon a cradle and an 11-pound weight hung from the heel. The calf of the leg had swelled up to 10 inches in diameter.

Dr. Newman's greeting to me the next day was, "So you're the boy who cheated me out of an amputation." He was very surly to everybody in the cast room and to me in particular. All the time when the leg was at its worst, he did not even say, "Good morning" or look at the leg for as much as 3 weeks at a time. Whenever I would ask him to make an adjustment of the pin or cradle, he would say,

"You can be damn lucky you have a leg to hurt you," and would do nothing. None of his expressions were made in a kidding manner, and he was very disagreeable to every patient. All the patients in the ward complained about his unnecessary roughness. After 6½ weeks, the pin had slipped in my heel and the heavy metal horseshoe had the flesh of the heel gouged right into the bone. I asked Dr. Newman to put it back in its proper position, but he would not even look at it. Three weeks after I had first asked him, the charge nurse came in with an orderly, moved the pin and adjusted the horseshoe. She said, "After all, the horseshoe pressing against the bone would cause serious trouble, and I would be responsible as well as the doctor." Dr. Newman had punctured the calf of the leg about 15 times with a scalpel to let out the stagnant blood. At night the blood would seep through the gauze pad under the calf and the gauze of the cradle and dry. Dr. Newman would brutally grasp the leg and tear it loose from the cradle, until one day a nurse said to me, "It is not necessary to suffer that way," and got a piece of oiled skin, which she placed between the gauze pad and cradle, and I was relieved of a lot of unnecessary pain. Because the foot was badly swollen and had gangrene, Dr. Newman could not figure any way to keep it upright. It kept falling down and destroying what circulation was being restored. I had a padded wooden strip made, with V bolts, which I fastened to the frame, which kept the bed clothing from the leg. After that the foot stayed up and the swelling and black gradually disappeared.

After 6 weeks had passed, I asked Dr. Newman for an X-ray. I could still feel the tibia move when I shifted my body. He said that he wished that X-rays had never been invented and that he could tell more with his fingers than from any X-ray. He placed about an inch of padding under the leg above the ankle. I called for Major Kenney (clinical director) and explained the case to him. He ordered an X-ray, which I received March 21. Then Dr. Newman changed and became about one-half human. He told me that I had a good setting and that I had started to make bone. He told me that I had a very bad leg, with gangrene, and it was up to me to get rid of the infection and that the bone break was very simple; that they had breaks like mine nearly every day and that if I could get rid of the infection there was no doubt about my leg getting well. As the weeks passed, I could see and feel that the leg was getting firmer. The orderly who held it up while the nurse dressed it remarked about how strong it was and that it no longer bent when moved. After about 12 weeks Dr. Newman seized the leg at the knee and ankle and twisted it very strongly in all directions. It did not move a bit at the break. He remarked, "By God, you've made bone and lots of it." I could move the foot to either side and could stand up in bed without a quiver at the break. Dr. Newman told me he was going to put plaster on the leg. I told him to leave it alone, even though it would be a little crooked, and I absolutely forbid him to rebreak the leg. The calf of the leg was down to normal without an open sore on it. I had gotten rid of the gangrene in the toes and had grown new toenails. The skin of the toes was pink, and I could wiggle them all. At this time Dr. Newman remarked, "Fensel, you've got me licked; and I don't know what to do with your leg." Why didn't he call in a specialist then?

On the 4th of May Dr. Newman took the leg from the cradle and removed the pin. He laid the leg on the bed and looked at it. Suddenly, without a word of warning to me, he raised the heel about 2 feet from the bed with one hand, with the other and with his shoulder weight behind it, he pressed down at the break. There was a pop, which all the men in the cast room heard and several out in the hall. He said, "There now, that looks like something." He left me lay there all that day and night until the following morning, May 5, without any order for pain relief. I was taken to the operating room where, without any anesthetic or local injection, he wrapped on a plaster dressing. When part was done, I felt a pain much more terrible than the others. I could not help but moan. It was right at the tibia break. Dr. Newman asked me what was the matter, and I told him, but he kept on and finished the cast. From then on I was in extreme pain at the slightest movement of the leg. I could not sit up or lie down in bed without agony. Even when motionless, the leg pained severely. When Dr. Newman finished wrapping the plaster dressing he said, "Well, I guess that will be all right." I said, "It had better be," and he answered, "Why should I care? It's not my leg." Just then a doctor came into the operating room and said, "That man's going to be knock-kneed as hell," but Dr. Newman did not answer him.

The reason for the doctor's remark was that for 14 weeks my leg had lain in a cradle which was too small for it. The part which slanted down to the



bed was too short for my thigh; consequently my body slid about 6 inches to the left of my leg. The cradle was nothing but a frame with gauze wound across; as time passed, the gauze loosened. That at my heel kept tight because the traction kept my heel up, but the rest dropped the leg until it became straight from a side view but with a 6-inch bow looking at it from the top. After 2 weeks of this suffering, on May 20, the leg was X-rayed, and Dr. Newman told me that the bones were set crooked in the cast. Also, when I felt that severe pain while he was putting the cast on, he must have pinched the flesh in between the bones. The cast was also wrapped on so tight below the metatarsal arch that I could not move the toes, and the bruised look which they got from holding the foot up when the cast was put on, never disappeared. The plaster dressing had been applied directly to the foot and leg without one bit of padding. A black toenail which had nearly grown out became a hard, thick, black bunch. Even though the X-ray showed that the bone was set wrong and that I was in agony day and night, Dr. Newman did not remove the top half of the cast until May 25, nearly a week later. There was a hole in the leg over 1 inch in diameter, with the bones sticking out into the air and cast. The cast was just swimming in pus. Dr. Newman's better-than-X-ray fingers sure did a swell job of messing my leg.

My wife then went to Colonel Thompson, chief medical officer, and told him we did not want to have Dr. Newman to have another thing to do with my leg. Dr. Dieterle, the bone consultant, was called in. He ordered the dry dressings, which Dr. Newman ordered, discontinued. He ordered hydrochloride dressings every 3 hours and, in about 4 days, the pus cleared up. At this time Dr. Newman lied to Colonel Thompson and said that the bone never had shown any signs of knitting. This was his way of crawling out of the botch he had made of my leg. On June 23 Dr. Dieterle performed an open reduction upon my leg. He found that the bone had become infected from Dr. Newman's faux pas, and he had to cut 1½ inches of bone off and screwed in a metal plate. He wrapped on a plaster dressing to about 10 inches above the knee. A window had been marked out in the cast at the break and this was removed July 12. Pus was still draining from the leg in the region of the break. Daily dry dressings were applied. On November 1 the cast was removed. I still could not move my toes and the foot pained me greatly. The place in the heel which Dr. Newman would not fix while I was in traction was very deep and would not heal. On October 9 the leg was X-rayed. Dr. Newman told me that I had made lots of bone on the side away from where the pus was coming out. The leg and foot pained me greatly, especially when moved.

On November 14 the leg was X-rayed again. It hurt terribly while being handled and afterward. I told Dr. Newman that I couldn't take it much longer, so he called in Dr. Dieterle again. I asked Dr. Dieterle what his honest opinion was, and he advised having it amputated. On November 17 I had the leg cut off just below the knee and am recovering very nicely from the operation. I am sure that the loss of my leg was entirely due to Dr. Newman. The traumatic gangrene which set in due to lack of proper attention after entering the hospital was gone. The fibula had knitted in the area where the circulation had been partially destroyed by the broken bones. If Dr. Newman had only lined up the bones right while in traction, and if he had not made a mess of the cast he put on, I would still have two legs. I feel that Dr. Dieterle did his best, but Dr. Newman did not leave him enough of a leg to do anything with. The nurses and orderlies gave me the best of care. If it were not for the wonderful attention given me by the nurses I feel as though I would have lost my leg a long time ago.

1. Dr. Newman was transferred from Sawtelle, Calif., against his wishes.
2. He did not like the Wisconsin climate.
3. He did not like Milwaukee.
4. There was more work at the Milwaukee hospital than he was used to doing.
5. He vented his spleen upon the patients in ward 14 by being abusive to them and not giving them the proper attention.
6. Patients were forced to go to the chief medical officer or clinical director to get ordinary medication and treatments when refused by Dr. Newman.
7. If a check were made upon patients who have been treated by Dr. Newman since he came here, you would find that only six patients have been treated successfully and that the rest are cripples.
8. Dr. Newman is known throughout the hospital as brutal and an unskilled orthopedic surgeon.
9. Patients went a. w. o. l. or a. m. a. because Dr. Newman was so rough with them or did not pay any attention to them for months.



10. Within the last 2 weeks, Dr. Bernard (clinical director) has gone through the ward every morning asking the patients how they are. Now Dr. Newman is more courteous to the patients and orders treatments right away.

11. As between the work turned out by Dr. Regan and by Dr. Newman would show how inefficiently ward 14 has been handled.

ARDEN E. FENSEL.

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December 19, 1940, while a patient in ward 15 and only 2 months after the amputation Dr. Newman brought a Mr. Bidwell of the Bidwell Better Limbs Co., to my bedside. Mr. Bidwell in the presence of Dr. Newman measured me for an artificial limb. He then wrapped a heavy elastic bandage over the bandages on my stump, to reduce it for the artificial leg. Neither Dr. Newman nor Mr. Bidwell took the bandages off the stump to note its condition. I had refused to let Dr. Newman treat me previous to the amputation so he did not know what condition the stump was in. The fact is that there was still an inch of infected bone which was draining and which Dr. Keller was probing every day so that it would not close from the outside first. The tight elastic bandage which Mr. Bidwell wrapped around it caused it to swell and caused so much pain that I removed it at 11 o'clock that night.

The following day my wife consulted an expert who told her that Mr. Bidwell's act was the very worst thing that could have been done. If I would have left them keep the reducer on, the infection would have traveled upward and eventually the leg would have to have been amputated above the knee.

Neither Dr. Newman nor Mr. Bidwell informed me that I could choose an artificial leg from any of the companies who had contracts with the Government. I am forced to conclude that he stunt they tried to pull off was done so that Mr. Bidwell would get the contract for the leg before I knew that I could select another company.

I am now wearing an artificial limb not furnished by Mr. Bidwell. I am having great difficulty with it on account of the crooked and locked knee, which is also the fault of Dr. Newman. The stump had to be fitted slanting in the socket of the wooden leg, so the leg would be straight. When I try to use what little movement I have in my knee the foot slides sideways on the floor. I also must keep the leg straight out in front of me when sitting and cannot sit in the regular position at the dining table. Ascending or descending stairs is a laborious process and at the present time am more handicapped than with an above-the-knee amputation, due to Dr. Newman's neglect. It must be that Dr. Newman did not mention how he crippled the knee when he examined me for the rating board. The X-ray showed the knee to be O. K. when I entered the hospital. As I have both shoulders and both hands crippled and a hernia, which has been operated on twice and is out for the third time, you must realize that I would have tough enough going even without the wooden leg and stiff knee which Dr. Newman so generously donated to me.

ARDEN E. FENSEL.

The chairman of the Committee on World War Veterans' Legislation placed in the record the supplemental report of the Honorable Errett P. Scrivner on the veterans' facility at Wadsworth, Kans., and the report on the veterans' facility and domiciliary barracks at Salina, Kans.

OCTOBER 4, 1945.

Hon. JOHN E. RANKIN,  
*Chairman, World War Veterans' Legislative Committee,*  
*House of Representatives, Washington, D. C.*

DEAR CHAIRMAN RANKIN: During the recent summer recess, I again visited the veterans' facility at Wadsworth, Kans. As you are undoubtedly aware, shortly after the visit made around Easter time, the manager, Colonel Pearsall, died. His successor, with whom I visited at length, has a comprehensive program for improvement composed of comparatively small details, all of which will be for the betterment of the hospital and to the added convenience of the patients. Most of the minor matters which did not seem to come up to par and which were noted and discussed at the earlier meeting had been corrected.

Although nearly all of the buildings which had been reconverted from domiciliary barracks to wards for NP cases had been completed, including the one separate building for women patients, on August 16 only one of these buildings was occupied due to the fact that this facility does not have a sufficiently large staff of doctors, nurses, and attendants to adequately care for a greater number of patients. In this one occupied ward I found that the patients were segregated into four different groups so that the milder cases were not in a ward with those who were more disturbed. All work had been completed in the NP receiving and surgical wards, so that it was there possible to segregate the disturbed from the mild cases.

The care of NP cases in this facility has been of such short duration that it was impossible to obtain any statistics which might indicate the effectiveness of the treatment being given.

Respectfully submitted.

ERRETT P. SCRIVNER.

OCTOBER 4, 1945.

Hon. JOHN E. RANKIN,  
*Chairman, World War Veterans' Legislative Committee,*  
*House of Representatives, Washington, D. C.*

DEAR CHAIRMAN RANKIN: During the recent summer recess, pursuant to authority therefor granted, I proceeded from Kansas City, Kans., to Salina to look over the proposed veterans' facility and domiciliary barracks.

I found that inasmuch as there had been some considerable delay between the time the Army gave up this installation which had been the base hospital for Camp Phillips, Kans., and the arrival of members of the Veterans' Administration, practically all of the hospital equipment had been disconnected and crated and, in many instances, completely removed from the site. After experiencing a great deal of difficulty in obtaining necessary authorization to proceed with certain installations, the progress made from February 1 to the time of my visit (August 14) had been practically nil.

Inasmuch as I have now been informed that this facility has been transferred to the Navy for operation as Navy hospital, it would serve no purpose to go further into the situation which I found existing there, except to point out that hereafter if the Veterans' Administration is to take over any Army or Navy installation, such transfer should take place without delay so that installations will not be removed, thereby delaying the immediate occupancy of the facility by the Veterans' Administration.

Respectfully submitted.

ERRETT P. SCRIVNER.

By direction of the chairman of the Committee on World War Veterans' Legislation, the report of the Honorable A. Leonard Allen, a member of this committee, on the veterans' hospitals at Johnson City, Tenn.; Murfreesboro, Tenn.; Memphis, Tenn.; Tuscaloosa, Ala., and Alexandria, La., is included in this report.

OCTOBER 15, 1945.

*The Chairman and Members, Committee on World War Veterans' Legislation, House of Representatives.*

GENTLEMEN: Complying with a mandate of this committee, I have investigated the veterans' hospitals at Johnson City, Tenn., Murfreesboro, Tenn., Memphis, Tenn., Tuscaloosa, Ala., and Alexandria, La. I file herewith and attach hereto my reports on these hospitals.

Very sincerely yours,

A. LEONARD ALLEN,  
Member of Congress.

#### MOUNTAIN HOME FACILITY, JOHNSON CITY, TENN.

This is a general and medical hospital. It is located on the edge of the very nice little city of Johnson City, Tenn. The buildings, for the most part, are old, having been built in 1933 as a home for Civil and Spanish War veterans. When the buildings and grounds were taken over by the Veterans' Administration for veterans of World War I many changes were made and the buildings were modernized.

This hospital has a layman for manager and has a separate chief medical officer to head the medical staff.

David H. Taylor, son of the noted Bob Taylor, has served the hospital for 20 years and for the past 3 years has been manager in the absence of Col. Lee V. Harr, who was in the Army. Colonel Harr returned from the Army and took over the management of the hospital the day after I left. I spent several hours talking with Mr. Taylor and also with Colonel Harr. I reached the conclusion that this hospital has had most excellent management, both by Mr. Taylor while acting manager and by Colonel Harr. I was interested to note that Colonel Harr, after being away in the Army for approximately 3 years, when going through the wards with me had a good word and a happy greeting for many patients whom he had evidently known before.

The medical staff was headed by Lt. Col. James H. Morrison, a native of Tennessee. Lieutenant Colonel Morrison has been in charge of the medical staff since 1935. I was assured that there was complete harmony between the management and the medical staff.

The hospital now has 18 doctors and 3 dentists. Lieutenant Colonel Morrison has made a request for additional doctors. While the patient load per doctor seemed nothing like as bad as in some hospitals, it is evident that more physicians will be needed to take care of the additional beds which are expected. While I did not get to meet all of the doctors in the hospital, I was assured by both the manager and the medical director that, on the whole, the cooperation, with one exception, was good, and the doctors were efficient. The chief medical officer stated to me that most of his doctors returned to the hospital almost every night to look after their patients.

The hospital has 54 nurse positions, and 22 cadet nurses the day I was there. There were 14 nurse positions vacant at that time, but the cadet nurses were filling in. The hospital has requested 24 additional nurses, which will make a total of 78 nurse positions.

The hospital had 99 attendant positions and all positions were filled the day I was there. Twenty-four additional attendants have been requested.

The present capacity of the hospital is 607 beds, and 287 additional beds have been requested and approved. This will give the hospital a bed capacity of 894. In addition to that, the hospital has 1,781 domiciliary beds now.

The hospital has provision for 29 tubercular patients, but these patients are transferred out as soon as possible. The hospital also has the provision of 28 neuropsychiatric beds, and those patients are likewise transferred out.

The kitchen and dining room for the tubercular patients was separate from every other connection with the hospital.

The sanitation was good, and the food appeared to be excellent and in reasonable quantities. Some patients expressed a desire for more food and they were



told that they could have a second helping at any time. Incidentally, I am told in these hospitals that, as a matter of fact, many patients do ask for a second helping and even more, and get it. I attach to this report a copy of the menu for several days.

#### CONCLUSIONS AND RECOMMENDATIONS

The hospital has no incinerator whatsoever. It is vitally necessary that this be attended to and one installed without delay.

The hospital definitely does not have adequate recreational facilities. The recreational room which I visited was not much larger than a congressional office. I recommend and urge that the Veterans' Administration look into this matter immediately and make provision for a recreational building, with adequate supervision.

The hospital has a most excellent chapel, accommodations for both Catholic and Protestant services being made. I urge that a full-time chaplain be employed. I think this should be done in every veterans' hospital.

One of the crying needs of this hospital is a new building to house the post store, barber shop, post office, various service organizations, etc. The present building used for this purpose is rather dilapidated, obsolete, and unsanitary. It can in no sense serve the purpose intended. It is entirely out of line with the balance of the hospital and detracts from the entire plant. No time should be lost in constructing a new building, centrally located, to serve these various purposes.

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#### MURFREESBORO HOSPITAL, MURFREESBORO, TENN.

This is a neuropsychiatric hospital. It is one of our newest hospitals, having been constructed in the latter part of 1929. It is modern in every respect. Maj. P. N. Jarrell is the chief medical officer and Mr. Sam Jarred is manager. The grounds were clean and well kept, but I believe a little more attention should be given to landscaping.

I saw nothing wrong with the sanitation and food.

This hospital, unlike the others I have visited, has a farm in connection and I wish to take occasion to highly commend what I saw being done on the farm. It is fair to say that the land purchased for this hospital and the farm was land that was largely worn out and very unproductive. It has not been an easy task to build it up. Great progress is being made in that direction, but it will take several years yet to rebuild the land. On the farm I saw many kinds of vegetables growing and a large part of the vegetables used in the hospital come from the farm. I also saw a nice lot of hogs. As I recall, I think they said they had around 300 hogs. It is my understanding that the hospital produces all the pork it uses. The hospital also buys feeder cattle and fattens about 40 percent of the beef used there, and hopes soon to produce all of the beef used in this way. I think patients are used to do some of the work on the farm, such work as they desire and are fitted to do, and I am thoroughly convinced of the therapeutic value of this. It is my considered opinion as a layman that other NP hospitals would do well to incorporate some of this in their programs where such is possible.

The greatest weakness I saw at this hospital, and the only material weakness that I recall, was the medical situation. For that reason I shall discuss it at greater length. I do not question the qualifications of the physicians.

As to the number of NP patients that one doctor can look after, the estimates vary anywhere from 30 up to 50 or 60. That is a matter on which I am not qualified to speak, but, as a layman, I reached the conclusion that perhaps every doctor in that hospital had a greater patient load than he should have had, and some of them had two or three times as many patients as they should have had. Indeed, it is difficult to see how they could hope to give anything like adequate consideration to the individual patient. For instance, Capt. G. B. Moore, a doctor with 11 years' experience in psychiatry, had 71 beds in his ward, with an average of 60 patients. His ward was the admission ward or reception center. It was his duty to make the provisional diagnosis when the patients came in. He had to interview each patient upon admission. He must of necessity talk with parents and other people who come to see about a patient. He must write all case reports and do a lot of other paper work. Under the regulations of the Veterans' Administration, he must see about all details, even to the clothing of the patients, check all valuables with the proper clerk, and in person must turn in all moneys to the manager. (See p. 33 of Veterans' Administration instruction.

Outline of Duties and Responsibilities of Field Personnel, approved February 1943.) Dr. Moore expressed the opinion that a reception center should be limited to about 20 or 30 patients a day in order to do a good job. He believes, however, that if he were given a stenographer to do the paper work and other nonprofessional and clerical work, and could be relieved of the nonprofessional responsibilities and could be permitted to devote his time exclusively to medical service, he could probably do justice to a ward having 60 patients.

Dr. A. W. White, who has had 20 years' experience in this work, has charge of the acutely disturbed cases, which embraced that day 206 patients, including suicidal and elopers. In addition to seeing after these patients, he also must hold numerous conferences with patients, with families, answer correspondence, see after the occupational therapy and physiotherapy details, keep medical records, clothing requisitions, and numerous other things. He said he made it a practice to shake hands with every patient in his ward every morning.

Maj. Sam Abel has charge of a ward with 241 beds. He had 186 patients the day I was there. He also has to do all the paper work and everything else that the other doctors must do. Major Abel has just returned from school at the Mason General Hospital under Dr. William C. Porter. He indicated that Dr. Porter was of the view that there should be no more than 40 NP patients to the doctor. He was of the opinion that his building should have at least three doctors instead of one. Incidentally, he had only one nurse and he felt there should be 1 nurse to every 30 or 40 patients.

I could go on and detail a similar situation in varying degrees with the other doctors. Dr. Jarrell, the chief medical officer, was of the opinion that the hospital needed at least five more doctors. I think he perhaps underestimated it.

The nurse situation was not good, but the hospital was not as greatly understaffed with nurses as it was with doctors. The hospital has 28 nurse positions, and when I was there it had eight vacancies and three were out on emergency leave. The chief nurse expressed the opinion that she would have sufficient nurses if all the 28 positions were filled. Certainly the hospital cannot do good work on less than that. Perhaps it needs more.

The hospital perhaps needs more attendants, also, but again, the attendant situation is nothing like as acute as the doctor problem.

The isolation ward under Major Adams, which now contains the tubercular, venereal, and other patients, is also used for colored bed patients who do not have contagious diseases. These patients who do not have contagious diseases certainly should not be placed with those patients who do have contagious diseases.

The more I see of these hospitals, the more I am convinced that it is poor economy to have doctors take up their time doing a huge amount of paper work. One doctor said to me that the answer to it was dictaphones or stenographers. Some hospitals have dictaphones; this one did not, that is, not for all the doctors. While I was talking with one doctor, an attendant brought in 10 separate slips of paper with reference to two patients who were going out on trial visits home. In one hospital, all day long, while I was with the medical officer, attendants came up a number of times with papers for him to sign or initial. Obviously, the doctor has to take somebody's word for it, and why he should be bothered with these details is something I cannot understand.

The hospital has one social-service worker whose entire time is utilized by the out-patient department. By all means the hospital should have at least one social-service worker to serve the patients. The services of one or more competent, sympathetic, social workers in this and other hospitals cannot be over-emphasized. I urgently recommend to the Veterans' Administration that it give more earnest consideration to the problem of increasing the number of social workers. I do not recall whether this hospital has a full-time chaplain or not. I think money spent to employ full-time chaplains for our hospitals is very wisely spent and I earnestly hope that at an early date the Veterans' Administration will see that every hospital has ample provisions along this line.

#### TUSCALOOSA HOSPITAL, TUSCALOOSA, ALA.

This is a neuropsychiatric hospital. It now has 728 beds, and there were 560 patients there the day of my visit. Included in the 728 beds are 49 beds for nonmental cases. The above figures show that the hospital is not now overcrowded. A splendid building program is in progress now which will give the hospital still a much larger capacity.

Lt. Col. George L. Johnson, a physician, is manager. He feels he has sufficient authority from Washington to do his job. Lt. Col. George H. Ingram is chief



medical officer. There was every indication that these two men were working together in closest harmony. Lieutenant Colonel Ingram told me he had had no trouble in his requisitions from Washington. They are both southern men, Lieutenant Colonel Johnson being from Georgia, and Lieutenant Colonel Ingram being from Alabama, and they seem to have a splendid grasp of local conditions and problems. They both gave me splendid cooperation. Lieutenant Colonel Ingram has been in neuropsychiatric work since 1923 and has been at this hospital since May 1944.

The hospital has no surgeon on its staff, but has operating facilities and when a surgeon is needed one is always available from the city of Tuscaloosa, 5 miles away. The hospital has 11 doctors in all. I found no evidence of incompetency or incompetency or insubordination upon the part of the medical staff.

The hospital has a quota of 32 nurses and I found the unusual situation that the entire quota was filled. The head nurse stated that she needed six more graduate nurses.

As to attendants, the hospital has 130 positions and 128 of these positions were filled at the time of my visit. I was advised that 11 more attendants would be required.

The officials considered the recreational facilities satisfactory. The hospital has a satisfactory incinerator. The sanitation of the hospital was good, and the food was excellent. I questioned a great many patients, many of them privately, and I found them to be satisfied. I had no serious complaints registered with me.

The hospital is equipped with distaphones and this greatly helps the doctors in their work.

This is an all-white hospital. While it is a neuropsychiatric hospital, it has 26 beds for patients who have tuberculosis. A very distinctive feature of this hospital is that it receives women patients, and I understand it is the only hospital in the South that does that, with a possible exception of one other. It has a capacity for 85 women patients and at the time of my visit it had 39 women patients.

It was advised that approximately half of the patients in this hospital are from World War II.

#### CONCLUSIONS AND RECOMMENDATIONS

While the load per doctor was not as great at the hospital as some others, I reached the definite conclusion that the hospital should have at least four more doctors for ward service alone. Lieutenant Colonel Ingram gave me the figure four, and I think that he was very conservative. Perhaps the heaviest load of any ward in the hospital is the ward handled by Major Roberts. His ward has a bed capacity of 189 and an average load of 150.

I recommend that at least six additional graduate nurses be provided, as requested by the head nurse. I also recommend that at least 15 more attendants be provided for, as was indicated by the hospital authorities.

The hospital has no swimming pool whatever available to the patients. The authorities would like very much to have a swimming pool. I am of the opinion it would have a direct therapeutic effect, and I recommend that one be provided.

The hospital grounds consist of 414 acres of land which formerly was very poor and worn out. The hospital has no livestock. I am definitely of the opinion that it would be very helpful to the patients to have an opportunity to do some work of a farming nature and to look after some livestock. I think this is especially true in view of the fact that a great percentage of the patients in this hospital come from farm families. I therefore reached the definite conclusion that the hospital should acquire at least 200 or 300 acres of land adjoining the present hospital grounds, and that some livestock should be acquired and reasonable farming operations designed to be helpful to the patients should be engaged in.

The canteen needs a sterilizer. This should be provided right away.

I met here the same complaint of too much paper work on the part of the doctors that I met in other places. I cannot too strongly urge that the office in Washington endeavor to work out some plan to permit these specialists to give their time to matters of medicine rather than to the filling out of thousands of forms, many of which could be handled by some clerical officer. In my opinion there has been too much restriction upon the part of the doctors in doing the things they consider necessary around the hospital. For instance, I was told that a doctor has to give an order to even repair a toilet, and I was further told that the utility man in the hospital could not repair it without an order. If these hospitals are to reach the degree of efficiency that we are striving for, it



seems to me that the doctors should be freed from all these details which it is possible to free them from.

Finally, I desire to state that this hospital appears to be in good hands, both from a managerial and medical standpoint. The recommendations that I have made are in no sense critical but are constructive.

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#### MEMPHIS HOSPITAL, MEMPHIS, TENN.

The Memphis Hospital is a general medical and surgical hospital. It was established in 1922. The hospital was built by the Methodist Church, but never used, and about the time of completion was taken over by the Veterans' Administration. It is well within the city of Memphis and is very crowded for land space. It has a bed capacity of 450, but 125 additional beds have been installed as an emergency, making a total bed capacity of 575. The hospital load runs around 485, and the capacity has never been reached. One hundred fifty additional beds have been planned and approved.

Col. C. D. Dodge is the manager. He has been in this sort of work since 1919 and has been manager at this hospital for 6 years. He is a doctor but confines his work to management in the hospital. Col. Joe E. Wheeler, of Meridian, Miss., is the clinical director and has charge of all medical work. Both of these gentlemen seem to be well qualified.

The hospital has 21 doctors assigned to it. A request has been made for two more doctors. I have found no serious doctor problem. There are 54 positions for nurses in the hospital. A unique situation prevails here in this respect because there was no nurse problem. I was advised that because of the peculiar situation in Memphis the hospital has always been able to obtain ample qualified nurses. Memphis has a number of schools for nurses and young ladies go there from a large area to take nursing, and this has simplified the nurse problem for this hospital. There are 83 attendant positions and all are filled. The hospital authorities advised me that they likewise had no attendant problem.

This hospital perhaps has a larger percentage of colored patients than any other veterans' hospital. About one-third of the patients are colored. I was advised that there is always a waiting list for the colored patients.

While the hospital was built back in 1922, it was well built at that time and is still rather modern. The buildings were clean and sanitary conditions were satisfactory. The food served seemed to have been well prepared and in sufficient quantities. The patients were aware of the fact that they could call for seconds, and I saw some doing that. I talked with a number of patients privately, and I found pretty general satisfaction.

The hospital has very great need for larger quarters, for a canteen, a post office, and other related matters. The present space allotted to this is entirely inadequate. Regardless of what disposition may be made of this hospital, I think immediate steps should be taken to remedy this particular situation, and I was informed that plans were being worked out along that line. The canteen should be equipped with a modern sterilizer. It has none now.

There is no provision for a home for the medical director. In fact, there is hardly room on the present limited grounds for that, but I think that a very serious effort should be made to make provision for quarters for the medical director and perhaps for the chief surgeon and maintenance man, either on the grounds or adjacent to the grounds. Certainly these men should be very close by at all times.

I think there is a plan perhaps to erect another building on the present grounds for hospital expansion. As I have previously indicated, the land is so limited that there is probably only about one place where this building can be placed and that space is so small that I have some doubts about the wisdom of it. There is a plan to add more stories on one of the buildings, which could be done economically and feasibly and which would add greatly to the efficiency of the hospital. It seems almost impossible to secure more land for the hospital. There is a large furniture factory right behind the hospital and adjacent to it which has been there some 50 years. There is a new and modern housing project on another side and adjacent to the hospital grounds. Modern homes adjoin the land on the other sides. Therefore, I do not see how more land could be acquired except at very great cost. I doubt the wisdom of doing that. In fact, I am not convinced of the wisdom of expanding the hospital except to increase the floors on one of the buildings and perhaps to make some changes in the front part of the main building, which was suggested to me by the manager.

I wish now to discuss something which to me appears as the most outstanding opportunity which I have met in any section I have visited in connection with veterans' hospitals. I refer to the fact that there is situated at Memphis perhaps one of the greatest medical hospitals of its kind anywhere in the world. This is the Kennedy General Hospital, built only about 2 years ago, and now operated by the Army. I visited this hospital and discussed the situation with the authorities there and I also discussed the situation with the authorities in the veterans' hospital. I also had the pleasure of going over this matter at length with the Honorable Walter Chandler, mayor of Memphis, and a former very valuable and able Member of the House of Representatives. I have also discussed it with the Honorable Cliff Davis, the present very able and influential Representative in the House from that congressional district.

This Kennedy General Hospital is like a city. It is of permanent construction, entirely modern in every respect, and the great probability is that it will be abandoned by the Army in the not too distant future, perhaps within 2 years or a little longer. This hospital at present can care for up around 6,000 patients, if my memory serves me correctly, and I think it had up in the neighborhood of 5,000 patients the day I was there. It is, therefore, large enough to more than amply meet any need which may arise in that section of the country for hospitalization of veterans. In fact, because of its strategic location, because of its very splendid and modern construction, and because of its great size, it appears to me that here is an opportunity for the Veterans' Administration to build a great medical center. There is ample room for specialization. For instance, it would be an easy matter to allot enough room in that hospital for a cancer clinic. The city of Memphis has for more than a half century had medical schools and today the city is equipped with a number of fine, modern, public and private hospitals. This would afford great opportunity for the medical staff of a greatly expanded veterans' hospital in the present quarters of Kennedy General Hospital to have ample medical contacts with other professional men. A great medical center here for veterans would be within a few hours automobile drive of much of Mississippi, much of Arkansas, some of Louisiana, and much of Tennessee and Missouri. This opens up an opportunity for expansion and specialization in the medical field for veterans in that entire section of the country which I think cannot be overlooked. Perhaps little would be required to convert this great hospital into a great medical center for veterans. It seems to be economical, it seems to be the part of wisdom, and I earnestly recommend that the Veterans' Administration take over this hospital as soon as the Army is in a position to abandon it and convert it into a great veterans' medical center.

The question now arises as to what should be done with the present veterans' hospital in Memphis. As I have pointed out, there is little room there for expansion. It was suggested to me that either one of two things could be done with this hospital. First, that it could be converted into a colored hospital. There is a large colored population in that entire section of the country. This committee has received a good report of the operation of the all-colored hospital at Tuskegee, Ala. In view of the fact that one-third of the patients at this hospital are now colored, and in view of the further fact that they have a colored waiting list, the present hospital no doubt could easily be filled at an early date by colored patients. Second, it was suggested that the present hospital might also be converted into a female hospital. So far as I know there is no provision so far for such a hospital. I found one hospital with a number of female patients. Undoubtedly, there will be considerable need along this line. We have had a great many women in the different branches of the armed services. I make no recommendation about the conversion of this hospital, but I simply point out that these two suggestions were made to me. Whatever disposition is made of the present hospital is a matter to be determined by the wise counsel of the Veterans' Administration in line with the needs of the future and in cooperation with the splendid citizens of Memphis and the surrounding country.

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#### ALEXANDRIA HOSPITAL, ALEXANDRIA, LA.

I spent an entire day in the Alexandria Hospital in company with several officials of veterans' organizations. I examined the food, took lunch at the facility, examined the kitchen, the cold-storage plant, and everything else connected with the hospital that we had time to see. I am not a physician. My investigation was handicapped to that extent. I have suggested at least twice to the com-



mittee the difficulty of men making these investigations who have no professional knowledge of medicine. I am not qualified to discuss medical questions in the facilities, and I shall not undertake to do so except to a very limited extent.

With reference to the food, I found the food, as a whole, good and apparently well prepared. The kitchens were exceedingly clean. In fact, from the point of cleanliness, I do not think anybody could, in good faith, criticize the facility, and I doubt that that condition could be improved. The food was wholesome and the quantities served to the patients, on the whole, appeared to be fairly sufficient, except in one particular which I will point out later. The hospital had on hand apparently an ample supply of the very choicest meats which can be secured anywhere. I secured several copies of the routine and special-diet menus and, without taking the time to read all of these, I believe that the members will agree upon perusal that these menus are illuminating and interesting.

The buildings were in good shape, perhaps a little painting being needed here and there, and the grounds were in excellent condition and were well cared for.

I was advised that the attendant situation was fairly good. New X-ray and dental equipment has been requisitioned and is coming. As to the nurse situation, that presented one of the worst pictures which I found in the hospital, but it was not surprising because I imagine that situation obtains in all public and private hospitals throughout the country. The hospital had 39 nurses when I was there and I was advised that it needs about 40 more. This is not a criticism of the hospital, but simply a statement of facts.

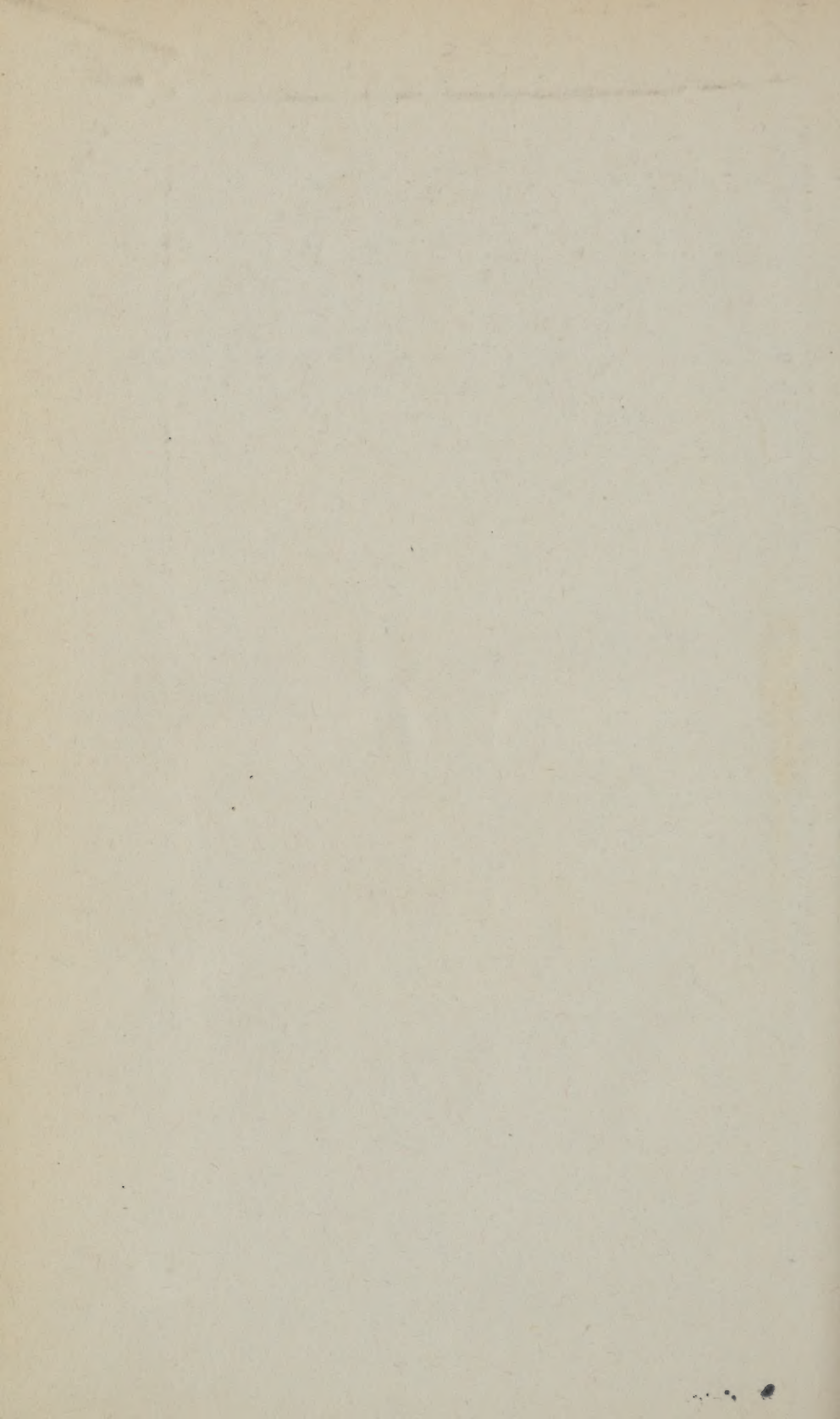
I come to the point of mentioning the most serious criticism which was presented to me by the patients. On the whole the patients seemed to be contented and satisfied. In the tubercular wards I encountered some dissatisfaction. This dissatisfaction did not come from all tubercular patients. Some emphatically told me that they were satisfied with the food and service which they were getting, but others indicated great dissatisfaction. The suggestion was made to me by some tubercular patients that they thought additional medical attention should be afforded the tubercular patients. The story was brought to me that a patient had had a collapse of his lungs and had had to suffer many hours because of the alleged absence of a doctor to give him air. This was the only occurrence of this nature which was presented to me. I feel sure that hospital authorities will take proper steps to prevent a recurrence of this. If additional medical help is needed in this ward, by all means it should be secured. Another complaint was made to me by some of the tubercular patients that their food was neither sufficient in quantity nor variety. I saw what the men were being served. I am certainly not a dietitian, but in view of the fact that it has long been understood that food is at least half the battle with tubercular patients, I am constrained to feel that it would be in order to give the tubercular patients larger servings in keeping with their appetites and physical conditions. It might also be possible to vary the kinds of food and the manner of cooking and serving so as to provide more variety to meet the objections of those who raised that point.

#### CONCLUSION

In conclusion, it will be noted from the above report I found no serious grounds for criticism of the facility, but, to the contrary, I concluded that the facility was being operated well, on the whole. I do not think that the widespread criticism which has been lodged against veterans' facilities in general is applicable, to any great extent, to this facility at Alexandria, La. I pointed out that the hospital needs at least 40 nurses. I suggest that the medical branch of the Veterans' Administration give consideration to placing additional doctors there if such are needed, especially in the tubercular wards. I make the further suggestion that more food with a little more variety be served to the tubercular patients who call for it.







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